the JOURNAL of the MICHIGAN STATE MEDICAL SOCIETY

Volume 45 MAR 9 19[illegible] Number 2

P. R. Urmston, M. D.
Bay City
MSMS President
1940-1941

FEBRUARY, 1946
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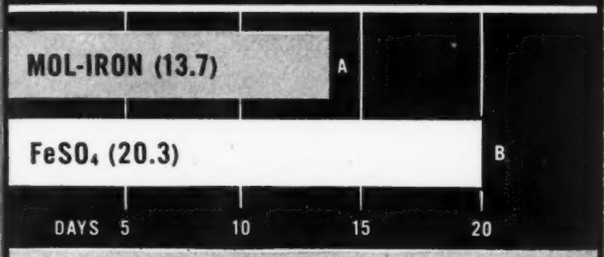
The Hand of Tim

MAPHARSEN now entering its thirteenth year of active clinical use, has assumed a leading role among arsenical antisyphilitics. More than 150,000,000 doses of MAPHARSEN have been used clinically during the past five years with a minimum of reaction and maximum of therapeutic effect.

PARKE, DAVI
& COMPANY

A NEW AND DEFINITE ADVANCE IN TREATING IRON-DEFICIENCY ANEMIAS

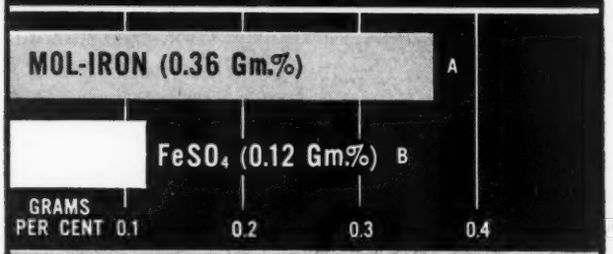
Rapidity of Clinical Response



(A) Completely effective therapeutic response (return to normal blood values) was obtained in an average of 13.7 days of Mol-Iron therapy.

(B) Ferrous sulfate therapy *failed* to produce normal hemoglobin values after an average of 20.3 days.

Average Daily Hemoglobin Increase



(A) The group treated with Mol-Iron averaged a daily hemoglobin increase of 2.48 per cent (0.36 Gm. per cent).

(B) The group treated with ferrous sulfate showed an average daily gain of hemoglobin of 0.83 per cent (0.12 Gm. per cent)—a response about one-third as effective.)

Therapeutic Intake of Bivalent Iron

(A) The Mol-Iron treated group received an average total of 3.528 Gms. of bivalent iron to produce the sought for result (return to normal blood values).

(B) While an average ingestion of 7.871 Gms. of bivalent iron failed to achieve an optimal response in the ferrous sulfate treated group.

The charts summarize the results of a controlled study of comparative therapeutic response in post-hemorrhagic and nutritional hypochromic anemias. The series includes 49 cases treated with Mol-Iron and 21 with exsiccated ferrous sulfate; the results are typical of those observed in treatment of iron-deficiency anemias with White's Mol-Iron.

A specially processed, co-precipitated complex of molybdenum oxide (3 mg.) and ferrous sulfate (195 mg.).

White's MOL-IRON TABLETS

Available clinical evidence indicates that, in hypochromic anemia, the therapeutic response to this highly effective synergistic combination—as compared with equivalent dosage of ferrous sulfate alone—has unusual advantages:

1. NORMAL HEMOGLOBIN VALUES ARE RESTORED MORE RAPIDLY, INCREASES IN THE RATE OF HEMOGLOBIN FORMATION BEING AS GREAT AS 100% OR MORE IN PATIENTS STUDIED.
2. IRON UTILIZATION IS SIMILARLY MORE COMPLETE.
3. GASTRO-INTESTINAL TOLERANCE IS NOTABLY SATISFACTORY—even among patients who have previously shown marked gastro-intestinal reactions following oral administration of other iron preparations.

INDICATED IN:

Hypochromic (iron deficiency) anemias caused by inadequate dietary intake or impaired intestinal absorption of iron; excessive utilization of iron, as in pregnancy and lactation; chronic hemorrhage.

DOSAGE: One or two tablets three times daily after meals.

Available in bottles of 100 and 1000 tablets.

Ethically promoted—not advertised to the laity.

WHITE LABORATORIES, INC.
Pharmaceutical Manufacturers, Newark 7, New Jersey

You and Your Business

WHAT THE PEOPLE THINK ABOUT HEALTH INSURANCE†

This survey, undertaken during June and July, 1944, was conducted by a nationally known impartial agency according to scientific principles assuring the most accurate results. It involved direct questioning of 4,968 persons in all walks of life throughout the state.

The Results

Question.—Do you think we should have some sort of a government-operated medical hospital plan?

The Vote.—

Yes	38.7%
No	42.8%
Don't know	18.5%

Comment.—Most national surveys have shown a considerable majority of the people favoring a governmental health care program. A high percentage of the Michigan population already has obtained non-governmental protection against the costs of sickness, however (see below). Satisfaction with non-governmental protection (which has been widely adopted in this state) evidently accounts for the difference between the Michigan and the national surveys.

Question.—If you were asked to choose, which of these plans for medical-hospital care would you prefer?

The Vote.—

Voluntary pre-payment program sponsored by the medical profession and hospitals	33.7%
Government-controlled program	15.5%
Regular insurance	13.4%
Union-controlled	.9%
Payment for service at time rendered	26.6%
Don't know	9.9%

Comment.—Obviously, the mere fact of offering the people a choice causes wide variations of opinion. Only 63.5% of the people are able to make an immediate choice among types of pre-payment programs—a point indicating the great need of public education in this field. However, of those who do choose amongst types of pre-payment health care programs:

75.5% choose voluntary as against governmental pre-payment plans.
53.0% choose pre-payment plans sponsored by the medical profession and hospitals.

Question.—Do you or any members of your family subscribe to a medical or hospital service plan for which a monthly fee is collected?

The Vote.—

Yes	41.5%
No	56.6%*
Don't know	1.9%

Comment.—Two of every five persons in Michigan already hold protection against the costs of sickness through voluntary (non-governmental) organizations. The number thus protected is increasing rapidly. An additional 163,000 persons have enrolled in the Michigan Blue Cross Plans (Michigan Hospital Service and Michigan Medical Service) since this survey was conducted.

†Highlights of a survey sponsored by the Michigan Health Council, Washington Blvd. Bldg.—Detroit 26, Michigan.

*The individual Doctor of Medicine has the responsibility of helping to lower this percentage by telling all the people of Michigan the advantages of voluntary group medical care coverage contrasted to compulsory, expensive, legislated schemes.

THE FOURTEENTH "FIRST" FOR MICHIGAN

The Michigan plan for furnishing home office medical care to veterans, by use of hometown doctors of medicine, represents "Another First for Michigan," to quote the phrase which has become a byword in medical circles outside this State.

The thirteen other "Firsts" sponsored by the Michigan State Medical Society within recent years include, briefly, Michigan Medical Service; Extra-mural Postgraduate Medical Education Courses in physicians' home communities; Michigan Foundation for Medical and Health Education, Inc.; commercial radio program over WJR every Friday evening at 6:30 p.m.; Annual Industrial Health Conferences; Detroit-Denver Medical Public Relations Conferences, leading to creation of "Conference of Presidents and Other Officers of State Medical Associations"; Development of "Outline" for needed medical legislation benefi-

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FOURTEENTH "FIRST" FOR MICHIGAN

(Continued from Page 150)

cial to the people; Michigan Rheumatic Fever Control Program, including formation of Diagnostic and Consultation Centers covering the State; Medical Veterans' Readjustment Program; Uniform Fee Schedule for Governmental Agencies; Cancer Detection Clinics; Organization of Michigan Health Council; and stimulation for creation of a "National Health Congress."

NO POPULAR VOTE ON COMPULSORY HEALTH INSURANCE

Many persons believe that the subject of compulsory health insurance will be placed before the voters of the country for final decision.

The fact is that any action taken on this important subject will be done by the federal Congress and not by general ballot.

It is anticipated that early hearings will be held in Congress on social security revision, including the Wagner-Murray-Dingell Bill and the Pepper Bill.

MICHIGAN MEDICAL SERVICE

To enable General Motors employes to keep their Michigan Medical Service and Michigan Hospital Service protection and group life insurance during the strike, the corporation opened all personnel offices to accept payments. For those financially unable to make payments, General Motors offered to advance the necessary funds and make deductions from future pay.

Employes were notified of these arrangements by extensive radio and newspaper publicity supplemented by a letter from the corporation mailed to the homes of all concerned.

Through this arrangement several thousand General Motors employes were enabled to continue their Michigan Medical Service and Michigan Hospital Service protection who otherwise would have been forced to let it lapse.

MEDICAL LAW ENFORCEMENT

October 31, 1945, marked another milestone in the case of William A. Kopprasch, pending an appeal which may be made by the attorneys, Joseph Hoffman and Miles.

William A. Kopprasch is a medical doctor of Allegan, Michigan, whose license to practice medicine in the State of Michigan was revoked on June 8, 1945, by the State Board of Registration in Medicine. The revocation was based on the arrest and sentence of William A. Kopprasch for violation of the Federal narcotics law involving the dispensing of narcotics through the mails. Narcotics were mailed to Jack Fisher under date of February 17, 1942, and March 11, 1942. Mr. Fisher was dead at the time the last bottle of narcotics was mailed to him.

Hardships have been encountered in this case, which has lingered in court from June 8, 1943, to October 31, 1945. Dr. Kopprasch was first licensed to practice in Michigan in 1924. From time to time complaints came in, were investigated and settled. After Dr. Kopprasch's license was revoked he continued to practice medicine, with the exception of writing narcotic prescriptions, and he did not advertise as boldly as he had before. He made no attempt to conceal the fact that he was practicing medicine. According to testimony in court he notified his patients that the practice of medicine was just an act of charity on his part, that he could prescribe and diagnose, but that he could not sign his name, that he could not charge any fee but that the patients could leave a specified amount on the desk when they left. One record, that of a birth under date of January 21, 1944, was completely filled out except for the doctor's signature. The birth record was signed by Della Ewers, the child's grandmother, a woman seventy-three years of age and so feeble that she could scarcely hold a glass of water.

Evidence was secured that Dr. Kopprasch was practicing medicine after his license had been revoked and on September 27, 1944, a complaint was issued by a very unwilling prosecutor. It was necessary to postpone the hearing until the election of a new prosecutor. Perle Fouch was elected prosecuting attorney. He was called upon before the election and promised that he would be willing to fight the case if he were elected.

Kopprasch secured as his attorney, Representative Miles, a practicing attorney from Saugatuck whose father is the presiding judge in Allegan County. He was also represented by Joseph Hoffman, son of Congressman Hoffman. Congressman Hoffman wrote suggesting that the prosecution should not continue with the trial. A letter was also sent to the governor's office which was answered by Mr. Schancupp who was then the legal representative for the State Board of Registration in Medicine.

On April 24, 1945, Dr. Kopprasch pleaded guilty in

(Continued on Page 166)

MICHIGAN HOSPITAL-MEDICAL SERVICE RATES

As of January 2, 1946

	Hospital		Surgical	Surgical & Medical
	Semi-Private	Ward		
Individual	$1.00	$ .80	60/90	90
Husband and Wife	2.20	1.80	1.60	2.20
Family	2.40	2.00	2.25	3.25

National Expansion of Medically-Sponsored Voluntary Group Health Care Plans

The Conference of Presidents and Other Officers of State Medical Associations, in session on December 2, 1945, in Chicago, adopted by unanimous vote a most important resolution which was subsequently presented to the AMA House of Delegates:

Council on Medical Service and Public Relations be instructed by the American Medical Association House of Delegates to correlate the various voluntary state and local programs in order to develop a group health care plan on a *national* basis, with uniform principles, rates, and reciprocity between all, for the benefit of subscribers located in all parts of the country.

CHICAGO CONFERENCE OF PRESIDENTS, DECEMBER 2, 1945
PRESIDENTS OF STATE MEDICAL SOCIETIES

(Front Row): C. H. Gellenthien, M.D., New Mexico; W. A. Bunten, M.D., Wyoming; J. H. Howard, M.D., Connecticut; P. K. Gilman, M.D., California; G. A. Unfug, M.D., Colorado; L. H. Schriver, M.D., Ohio; Cleveland Thompson, M.D., Georgia.

(Middle Row): Chas. McMartin, M.D., Nebraska; D. J. Hurley, M.D., Nevada; J. W. Stovall, M.D., Kentucky; V. C. Tisdal, M.D., Oklahoma; J. L. Rawls, M.D., Virginia; R. S. Morrish, M.D., Michigan.

(Back Row): A. S. Bristow, M.D., Missouri; G. H. Anderson, M.D., Washington; R. T. Woolsey, M.D., Utah; R. D. Bernard, M.D., Iowa.

Present at Conference but absent when picture was taken: E. P. Coleman, M.D., Illinois; A. P. Leighton, M.D., Maine; W. L. Estes, Jr., M.D., Pennsylvania; W. C. Chaney, M.D., Tennessee; P. R. Minahan, M.D., Wisconsin.

WHEREAS, group health care programs, sponsored and operated by the medical profession in many parts of the country, are providing the means whereby millions of persons are able to secure good medical care and hospital service on a voluntary budgeted basis; and

WHEREAS, This health care has been rendered in a manner highly satisfactory to both patient and physician, resulting in better understanding between both; and

WHEREAS, The voluntary type of group health care is to be preferred—in the interest of the people's health—to compulsory, political control; and

WHEREAS, Some areas of the country have no such programs in operation at the present time; and

WHEREAS, A large proportion of the people desire group health service on a national basis; therefore be it

RESOLVED, That the President and other officers of every State Medical Society use their best efforts to secure prompt action by their State Society in inaugurating new, or increasing the benefits of existing pre-payment health care programs in every state; and be it further

RESOLVED, That the American Medical Association

The AMA House of Delegates approved this resolution on December 5, by adopting the report of the Reference Committee on Legislation and Public Relations which read in part:

"Your reference committee has reviewed several resolutions calling for the adoption of voluntary prepayment medical care plans. **All of these plans show a uniformity of desire for the immediate setting up of a national plan on a voluntary basis. In all of them the urgency of this being done is stressed. Accordingly your reference committee recommends that the House of Delegates of the American Medical Association instruct the Board of Trustees and the Council on Medical Service and Public Relations to proceed as promptly as possible with the development of a specific national health program, with emphasis on the nationwide organization of locally administered prepayment medical plans sponsored by medical societies."**

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Action by AMA

The Council on Medical Service and Public Relations sprang into action. It appointed a subcommittee which held meetings in Toledo on December 16 and in Chicago on January 11. A specific national health program was developed, following the instruction of the AMA House of Delegates, and was presented to the Board of Trustees.

On February 12, the Board approved the general principles and created a division of Medical Care Plans under the Council on Medical Service. Further, it instructed that a director be employed at once to integrate voluntary group medical care plans in every state in the Union and to standardize existing programs, insofar as possible, for the benefit of subscribers. The Council on Medical Service is to award the use of its seal by all approved medical care plans.

Simultaneous with this progressive action by the AMA Board of Trustees, the medical care plans of the United States incorporated in Illinois on February 12 as the "Associated Medical Care Plans, Inc." This corporation will also stimulate the organization and spread of voluntary group health care programs, to the end that all persons who desire protection may find it available in all parts of the United States.

* * *

The Conference of Presidents and Other Officers of State Medical Associations is to be congratulated on its initial success in obtaining prompt action on a matter of such grave import as that contained in its resolution on Voluntary Group Health Care Programs.

Other resolutions adopted by the group are as follows:

Resolution Re Formation of a National Health Congress

WHEREAS, Proposed federal legislation to socialize health service would regiment doctors of medicine, dentists, hospitals, nurses, pharmacists, and the people whom they serve; and

WHEREAS, The Medical and allied health professions are intensely interested in bringing the greatest amount of health protection to all people in this nation, through those means which will both preserve and extend the high standards of health now prevailing in this country; and

WHEREAS, In order to preserve quality health care for the people of this nation, each of these groups favors voluntary non-profit prepayment plans instead of health services under compulsory governmental control; and

WHEREAS, While each of the groups in the health field has its own organization, working independently for the preservation of the American system of health care, an over-all body or council is necessary to integrate the necessary collective thinking and activity of all organizations or units; and

WHEREAS, A serious and immediate need exists to develop a working liaison or congress of all agencies in the health field to secure the most effective results of action and public education; therefore be it

RESOLVED, That this body recognizes the need for a National Health Congress representative of the medical, dental, hospital, nursing, pharmaceutical and allied professions, and that it approves the creation of such a coordinating body; and be it further

RESOLVED, That the American Medical Association Council on Medical Service and Public Relations be instructed by the American Medical Association House of Delegates to take the initiative in bringing together the interested groups to organize and incorporate immediately a National Health Congress; this Congress to undertake to bring to all the people of this nation the complete benefits of modern Medical-Dental science and the finest hospital facilities; this Congress to arrange for budgeting the cost of such services at monthly rates within the financial means of all Americans through voluntary, non-profit health plans; this Congress to speedily work for the institution of such voluntary non-profit health plans in those places or localities where they do not now exist.

Upon motion this resolution was adopted by unanimous vote.

Resolution Re Modern Medical Public Relations

WHEREAS, The economic trends of medicine point to an increasing effort on the part of organized minorities to regiment medicine; and

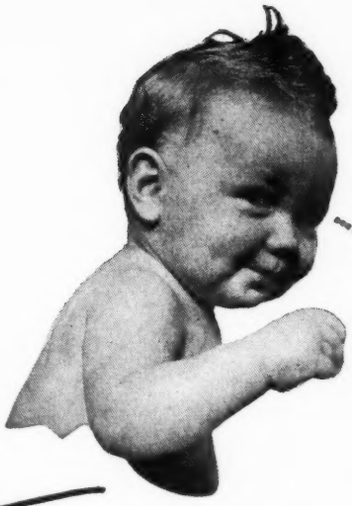
WHEREAS, The medical profession must take the public more and more into its confidence and tell all the people what Medicine has done, is doing, and intends to do for the public good; and

WHEREAS, Organized medicine urgently needs full-time public relations activity not only on a national level but in every State of the Union to inform the public properly of its ideals and programs; therefore be it

RESOLVED, That the President and other officers of each State Medical Society use their influence to create a well-financed public relations program in every State Medical Society at the earliest possible moment; and be it further

RESOLVED, That the American Medical Association Council on Medical Service and Public Relations be instructed by American Medical Association House of Delegates to offer sustained leadership to State Medical Societies in their public relations programs, especially through the example of an immediate and outstanding program of medical public relations on a national level employing newspapers, commercial radio and movies, and all other modern media, to bring Medicine's glorious story to the American people.

Upon motion this resolution was adopted by unanimous vote.



The foundation is the thing!

Built on a *firm foundation,* the Leaning Tower of Pisa has withstood the centuries . . . so, too, health and vigor in infancy and the years ahead depend on a *firm foundation* of optimum nutrition. • BIOLAC, when supplemented with vitamin C, is a valuable infant food whose ample milk proteins constitute an adequate source of all essential amino acids . . . the indispensable *foundation stones* for sound tissues. • BIOLAC closely approximates mother's milk in safety, simplicity, and nutritional value.

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ACCEPTED AMERICAN MEDICAL ASSN Council on Foods and Nutrition

Biolac is a liquid modified milk, prepared from whole and skim milk with added lactose, and fortified with vitamin B_1, concentrate of vitamins A and D from cod liver oil, and iron citrate. Evaporated, homogenized and sterilized, Biolac is available in 13 fl. oz. cans at all drug stores.

Quickly prepared . . . easily calculated: 1 fl. oz. Biolac to 1½ fl. oz. water per lb. of body weight.

Veterans' Medical Care in Michigan

MAJ. GEN. HAWLEY

"Home town care of veterans" for service-connected disabilities, with free choice of doctors, is offered as a standard practice for the first time through the far-reaching agreement signed December 27, 1945, by representatives of the Veterans Administration and the Michigan State Medical Society.

By moving to use existing agencies, Gen. Omar N. Bradley, Veterans Administrator, and Maj. Gen. Paul R. Hawley, Acting Surgeon General, have:

Introduced a practical plan for veterans medical and hospital care which can be in full operation in months rather than years.

Developed a pattern which, if pursued nationally, will save much time and expense otherwise required for travel of veterans to veterans institutions.

Advanced further toward Gen. Bradley's announced policy of decentralization, so that local needs can be met most effectively.

The agreement, which already has become a blueprint for care of veterans throughout the nation, permits veterans to receive treatment and care from local doctors of medicine. In a great many cases it will make it unnecessary for veterans to leave families, friends, and family physicians to go to veterans institutions which may be distant from their homes.

Doctors providing service to veterans are reimbursed through Michigan Medical Service, the non-profit pre-payment organization established by the Michigan medical profession. In turn, the actual cost to Michigan Medical Service is re-paid by the Veterans Administration.

In practice, the program works much like that by which Michigan Medical Service now provides medical services to more than 868,000 residents of Michigan.

For treatment or care necessitated by service-connected disability, the male veteran applies by mail, or by telephone in emergencies, to the Veterans Administration; he secures a case number permitting him to obtain a medical examination from any doctor of medicine participating in the program; after the examination—to determine if it is a case of the type provided by the veterans program—the veteran obtains authorization from the Veterans Administration for treatment. Immediately, Michigan Medical Service is authorized to make payment for medical care. Veterans Administration offices have been opened near M.M.S. headquarters in Detroit so that authorization of payments will not be delayed.

Special provisions are made for veterans of the women's services. Since they cannot be accommodated at present in all Veterans Hospitals, they are entitled to local care for both service-connected and non-service-connected disabilities.

The schedule of fees paid to doctors has been approved by the Veterans Administration. This is the Uniform Fee Schedule for Governmental Agencies, adopted by the 1945 MSMS House of Delegates after a special committee of the Michigan State Medical Society had given it prolonged study.

PARTICIPATION BLANK

All MSMS members are urged to become participating physicians under the V.A. plan, since veterans are being told to seek medical care from their own doctors. If you have not already done so, execute the participation blank printed below and rush to Secretary L. Fernald Foster, M.D., 2020 Olds Tower, Lansing 8.

Please file my acceptance of appointment as a fee-designated physician under the plan for veterans' care outlined in your Secretary's Letter No. 98 dated December 26, 1945.

(Signed) ..... M.D.

..... Street .....
(Date)

City .....

Public Relations Counsellor

HUGH W. BRENNEMAN

Hugh W. Brenneman was appointed Public Relations Counsel for the Michigan State Medical Society by The Council in annual session, January 19, 1946. His headquarters will be at 2020 Olds Tower, Lansing. As Lt. Brenneman he has shortly returned from naval service as a Destroyer Communication and Public Relations officer.

For seven years previous to the war he was active in public education and in the various fields connected with dissemination of information to the public.

Graduating from Alma College in 1936 he left an enviable record in all-round scholarship and collegiate activity. The record shows him to be the Michigan State Intercollegiate oratorical champion in 1935, Publicity Director of Alma College in 1936, four years a varsity debater, track athlete, member of the a Capella choir and the Alma College Band of which he was president in 1935 and 1936. In the latter capacity he wrote, directed and produced an all-college three-act musical comedy that received national recognition. Much of his schooling was paid for by his work as a representative of the Associated Press and outstate newspapers.

Upon graduation, he became active in secondary school work as a Public Speaking teacher and three years later was made principal of the Consolidated High School at Mesick, Michigan. In 1940 he was named president of the Wexford-Missaukee Teachers Association. In 1941 he deserted the school field for the larger teaching opportunities of radio. Employed by Radio Station WTCM in Traverse City, Michigan, he was soon a valued announcer and in charge of all educational programs on the station. His work attracted attention and he moved to the larger radio station WFDF at Flint, Michigan. As news announcer and in connection with the educational programs leading up to the war effort, he became well known in central Michigan. He was instrumental in the organization of the Rainbow Radio Productions Company.

Mr. Brenneman is thirty years of age, is married to the former June Redman of Ithaca, Michigan. They have one son, aged seven months.

Mr. Brenneman is new, but not unknown to us. His qualifications are such that we can expect results within a reasonable time.

The job of medical public relations is new; the work to be done is big; the difficulties many; there are few precedents to follow.

Mr. Brenneman needs the complete co-operation of every practitioner of medicine in his work of interpreting to the public the socio-economic problems of medical practice. If the members aid him in his work, and make use of his services at every available opportunity, we feel sure he will make the augmented public relations program of the Michigan State Medical Society a proud success.

MSMS ANNUAL SESSION

Wednesday, Thursday, Friday

September 25-26-27, 1946

BOOK-CADILLAC HOTEL

DETROIT

• A VICTORY MEETING •

MEDICAL LAW ENFORCEMENT

(Continued from Page 152)

Circuit Court on the charge of practising medicine without a license. Later the case was taken up by the presiding judge, another attorney was hired, his plea of guilty was withdrawn, and the case was referred back to Circuit Court for trial.

On October 31, 1945, the case was finally heard in Circuit Court in Allegan. After forty minutes' deliberation, the jury brought in a verdict of guilty. Kopprasch was fined twenty-five dollars and costs or sixty days in the county jail.

EDITOR'S NOTE: This case will be of interest to older practitioners in the Southern part of the state, as Dr. Kopprasch appeared against several of them in malpractice suits.

WAITING ROOM THERAPY

Plays an Important Part in a Doctor's Success

Treatment of your patients starts the moment they enter your waiting room. The little friendly gestures directed for their comfort create a relaxed and warm attitude toward their Doctor. What could be better than to have a copy of their favorite daily newspaper, "The Detroit Times," waiting for them? It will give your reception room a timely and up-to-the-minute touch, with its host of sparkling, compact features.

A Supply of Stickers

To emphasize your courtesy to the patient and to keep the newspaper in good order for the next reader —we have prepared a simple and attractive gummed sticker which can be attached to each day's paper in the twinkle of an eye by your nurse. The wording is as follows: "*Dear Patient . . . Your Doctor has arranged to have this paper here as a courtesy to you. Please leave it neatly together for the next person. Thanks.*" A supply of these stickers, at no charge of course, will be sent to you on request with your subscription.

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THE DETROIT TIMES

A GOOD NEWSPAPER

Medical Veterans' Readjustment

INDUSTRIAL HEALTH CONFERENCES

A series of thirteen weekly conferences entitled "Advanced Procedures in Industrial Employment" opened Wednesday evening, January 9, 1946, under the sponsorship of the Wayne University School of Occupational Health, according to Dr. Raymond Hussey, dean of the School and chairman of the series. The first session will begin at 4:30 p.m, in the eighth floor conference room of the Crowley-Milner East Building and will continue until 9:00 p.m., with an intermission for dinner.

Speaking at the conferences will be internationally known authorities in the field, including Dr. William P. Yant, Mine Safety Appliance Company, Pittsburgh; Dr. H. D. Storms, Director, Rehabilitation Clinic, Toronto; Miss Marjorie Fish, Director of Occupational Therapy, Columbia University Medical Center; Dr. W. A. Sawyer, Medical Director, Eastman Kodak Company, Rochester; Dr. C. O. Sappington, Mellon Institute, Pittsburgh; and Dr. Harvey Bartle, recently retired as Medical Director, Pennsylvania Railroad.

Says Dr. Hussey, "The subject of these new conferences is both vital and timely. Experiences during the war just terminated have yielded much new information about selective job placement, the care of disabling illnesses, and the restoration of injured persons. Today, when proper procedures are followed, the period of disability can be held to a minimum and be followed by maximum restoration and complete vocational rehabilitation.

"We will welcome the enrollment of plant personnel directors, superintendents and others who work directly with employe activities, as well as physicians who are interested in the practice of medicine as it relates to industrial health."

The complete program for the series is as follows: January 9, "Recovery and Convalescence as Related to Traumatic Injury"; January 16, "Occupational Restoration Following Traumatic Injury"; January 23, "Evaluation of Occupational Capacity and Ability Following Traumatic Injury"; January 30, "Employment of Handicapped Persons"; February 6, "Occupational Therapy and Vocational Rehabilitation"; February 13, "Selective Job Placement and Job Adjustment"; and February 20, to be announced.

February 27, "Developments in the Field of Industrial Safety"; March 6, "The Relation of Nutrition to Industrial Employment"; March 13, "Relation of Private Practitioner to Employe Health Programs"; March 20, "Special Problems of Women in Industrial Employment"; March 27, "Medical Examinations in Relation to Industrial Employment"; and April 3, "Administrative Medicine in Industrial Organization."

A folder describing the series in detail may be obtained at the Office of the Dean, School of Occupational Health of Wayne University, 4072 Penobscot Building, Detroit 26.

OPPORTUNITY DESIRED

A young doctor of medicine writes as follows:

"I am interested in assisting or becoming associated with some older physician in Michigan with the view in mind of eventually buying his practice.

"In 1941 I graduated from Rush Medical College, University of Chicago, and had a one year rotating internship at Ancker Hospital, Saint Paul, Minnesota, 1941-42.

"I am twenty-eight years of age, married and of Norwegian descent.

"In July, 1942, I was inducted into the Army and served three years overseas as follows: nineteen months with a portable surgical hospital; six months with a psychiatric unit and nine months with a general hospital doing general medicine. At present I am on terminal leave and shall be formally released February 26, 1946."

Address Capt. S. care JMSMS, 2020 Olds Tower, Lansing 8, Michigan.

REFRESHER TRAINING FOR DOCTORS LEAVING SERVICE

Refresher training of twelve weeks' duration will be given Army doctors leaving the service who desire to brush up on latest developments in fields of medicine, surgery, or neuropsychiatry in which they may not have been actively practicing during the past year, Major General Norman T. Kirk, Surgeon General of the Army, announced January 1, 1946.

This training which will prepare retiring Army doctors for return to private practice with latest knowledge of medical advances made during the war, will be given at Army hospitals until June 30, 1946. Reserve Corps, National Guard, and AUS Medical Corps officers who are to be separated will be eligible for this schooling.

The election of the period of refresher training is entirely voluntary, and applications may be made through channels to The Surgeon General in the case of medical officers assigned to the Army Service Forces, Army Ground Forces and Army Air Forces. Medical officers returning from overseas may make application for refresher training from the Reception Stations or Separation Centers through the ASF Liaison Officer directly to The Surgeon General. It is pointed out that medical officers cannot be recalled to active duty from terminal leave for the purpose of accepting a professional assignment for refresher training.

Numerous requests have been received by The Surgeon General from Reserve Corps, National Guard, and AUS Medical Corps officers who are about to be separat-

(Continued on Page 178)

EDITOR'S NOTE: This program was announced too late for most of the men who would have liked it. It should include terms of training at civilian hospitals, however, as the very thing the doctors are trying to remedy is the narrowed experience in military hospitals, and this training is given in army hospitals.

therapeutic action

★ Therapeutically, Ertron is unique in its antiarthritic activity. Many patients in large series of clinical studies have experienced restoration of movement in affected joints, relief of pain and measurable evidence of reduced swelling.

chemical composition

★ It can now be said that chemically, too, Ertron is unique. Ertron differs in chemical composition from the ordinary vitamin D preparations—a fact that undoubtedly accounts for the excellent results obtained with Ertron.

Simply stated, Ertron is electrically activated vaporized ergosterol prepared by the Whittier Process.

Ertron contains a number of hitherto unrecognized factors which are members of the steroid group. The isolation and identification of these substances in pure chemical form further establishes the chemical as well as the therapeutic uniqueness of Ertron.

Each capsule of Ertron contains 5 mg. of activation-products having a potency of not less than 50,000 U.S.P. Units of vitamin D.

ertronization therapy

★ To Ertronize the arthritic patient, employ Ertron in adequate daily dosage over a sufficiently long period to produce beneficial results. The usual procedure is to start with 2 or 3 capsules daily, increasing the dosage by 1 capsule a day every three days until 6 capsules a day are given. Maintain medication until maximum improvement occurs. A glass of milk, three times daily following medication, is advised.

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Editorial Comment

THE PEPPER BILL

When the EMIC program was put into effect, medical editors throughout the country, and many lay editors, also, prophesied that that program was an entering wedge, a trial balloon, by socialized medically minded members of the Administration in Washington, and that if it worked, it would serve as a model for similar legislation when that program ended.

Well, here it is.

—*Editorial, Rocky Mountain Medical Journal* Dec., 1945

* * *

JUST ANOTHER INCIDENT

A few months ago there was nationwide furror over the bureaucratic shortcomings of the Veterans Administration. Shamefully inadequate and obsolete practices were exposed in the veterans hospitals. But the rush of events quickly pushed the incident onto the back pages. And, like many such incidents, the public has heard no more.

Here is a typical illustration of what would happen if the whole country should be included in a politically administered medical system. Individuals would be subjected, as the veterans were and perhaps still are, to questionable or incompetent care. As individuals, they could do nothing more than vent their displeasure. Trying to ferret out officials responsible for ill treatment would be akin to grappling with one's shadow. When the situation became bad enough, a rash of condemnation would appear in the press. Investigation would be promised—as they were in the case of the Veterans Administration—a few of the most glaring faults would be corrected, and then the evil system would settle down for another twenty years or so of dozing dogma and inefficiency.

This is no exaggeration. It is what would be faced by the people if they permit state or socialized medicine, whichever you wish to call it, to settle upon the country. It is the normal procedure of bureaucracy.—Editorial, *Mississippi Doctor,* Dec., 1945.

* * *

AMA HOUSE OF DELEGATES' MEETING

The outstanding feature of the meeting was the passing of a resolution presented by the Council on Medical Service and Public Relations calling for a national health plan. The background of this resolution is interesting. Last April a meeting of the presidents of seventeen state associations was held in Detroit to reach the grass roots of medicine. These representatives were pledged to study the needs of their own state and bring statements of policy to be presented to the Council on Medical Service and Public Relations for transmittal to the House of Delegates. A second meeting was held prior to the meeting of the House, with more than forty states represented, and the resolution coming from this group was a true expression of the sentiment of the rank and file of the medical profession.

The Council on Medical Service and Public Relations also held two meetings with the same objective, one in October and one in November and consequently its resolution emanating as it did from the presidents and representatives of all states, carried the weight of study, thought, and desire.

In my knowledge, this is the first time a subject of such vast importance to the Association has been presented to the House of Delegates after detailed study and in concrete form. A mandate has been given to the trustees and the Council on Medical Service and Public Relations to prepare and activate a national health plan. This should accomplish much toward an answer to government medicine, and I am sure we in Iowa are strong in approval—R. D. Bernard, M.D., President, Iowa State Medical Society.

* * *

HOME-MADE CARE

The selection of Michigan as a proving ground for a Veterans Administration plan of "home-town care" for disabled veterans is a graphic demonstration of the unexpected fruits of home-town initiative.

The announcement of the arrangement makes it clear that Michigan was picked for this unique program of medical and hospital care for former servicemen principally because this state has perhaps the earliest, and by far the largest and most successful, private group medical care plan operating anywhere in the United States—the Michigan Medical and Hospital Services.

And Michigan has this successful medical and hospital service primarily because the leadership of

(Continued on Page 176)

It's The Law, Doctor!

Juris ignorantia est, cum jus nostrom ignoramus—Old Maxim

NOTES ON COURT DECISIONS, STATUTES AND OTHER AUTHORITIES

J. JOSEPH HERBERT, LL.B., General Counsel MSMS
Manistique, Michigan

MEASURE OF SKILL IN TREATMENT BY CULTIST—MALPRACTICE—EXPERT TESTIMONY

For years the healing cultist has in the diagnosis and treatment of human ailments had the benefit of two protective rules of law. The first of these is that in a malpractice action he is entitled to have the quality of his services tested by the teachings of his own cult or system. The second, a corollary of the first, is that the answer to whether or not he exercised the requisite care and skill must rest on the testimony of competent practitioners of his own cult or system.

In deed, the principle that a healer's preformance is to be judged by the tenets of his own school was emphatically reaffirmed in the leading Michigan case of Janssen v. Mulder, 232 Mich., 183, lately discussed in this column in another connection (JMSMS June 1945 p. 546). This was a case in which a chiropractor undertook to treat a child suffering from diphtheria. The child died and the chiropractor was sued for malpractice, The court said,

"While not registered, the defendant was a graduate of a chiropractic school. He but assumed to treat human ailments in accordance with the system taught in such school. This fact was well known to plaintiff. The burden was therefore cast upon her to show by competent evidence, not only that his treatment was injurious or not effective, but that the requisite care and skill was not exercised by him in administering it. It necessarily follows that such proof must be made by one engaged in treatment by similar methods to those employed by defendant. With the merits of the several drugless systems of relieving human ailments the courts have no concern. It is sufficient to say that many of our citizens believe in their efficacy and secure the services of those engaged in practicing them. The treatment given by any one of such practitioners would probably be deemed improper and unskillful when judged by physicians who are taught to treat such ailments by the use of drugs and medicines. The unfairness of permitting the test as to whether a particular treatment was proper or skilful to be determined by one who uses a different method, or follows the teaching of another system, must be manifest."

Recently, however, the Wisconsin Supreme Court has made a significant modification of the rule, in the case of Treptau v. Behrens Spa, 20 N.W. 2d. 108 (October 16, 1945).

In effect, the Wisconsin Court said that the old rule will not afford the cultist protection if he employs treatment outside the regular methods advocated by his particular cult or school of healing. The Court also sustained the testimony of doctors of medicine on points in relation to diagnosis and treatment as to which principles of "regular" and "irregular" schools do or should concur.

In light of the fact that today many cultists are in their procedures invading the field of medical practice, the Wisconsin decision certainly offers a more realistic approach to this troublesome problem.

The facts in the Wisconsin case were as follows: The plaintiff, Mrs. Treptau, went to the defendant, Behrens Spa, an incorporated hospital and sanatorium, for treatment of what she thought was a sprain of her right foot. The Spa employed both chiropractors and physicians. She was told by one of the chiropractors that she needed vertebra "adjustments." Two of the chiropractors gave her a number of so-called adjustments, in the course of which the swelling and painfulness of the foot increased greatly. One of the chiropractors then took an x-ray of the foot and, after palpation, pronounced that the patient was suffering from arthritis. Thereupon, the chiropractor applied circular bandages tightly about the foot and ordered heat diathermy treatments to be applied immediately. These heat treatments were continued for several days while the foot was tightly bandaged. The patient complained of great pain, the foot began to swell increasingly and became black and blue. She begged the nurses to help her take the tape off, which they finally did. The plaintiff returned to her home and called a doctor of medicine for treatment. Subsequently the foot lost flexion and became permanently impaired in function. The patient brought suit for malpractice.

On trial, the physician who treated the plaintiff after her chiropractic experience, testified that when he first saw the patient her foot was extremely swollen, tender to touch, discolored and that the condition indicated a markedly impaired circulation as a result of which gangrene threatened. He gave it as his opinion that the impaired circulation and the condition which he found was the result of the constricting tape and diathermic treatments while the tape was in place, and that he believed the treatment which was given was not in accord with the recognized proper practice in that community. Two other physicians testified to like effect.

The defense was twofold, first, that the patient, having consulted a chiropractor, thereby accepted the kind of treatment approved by that school of healing, and

(Continued on Page 176)

gentle reminder

For the patient with functional constipation, 'AGAROL'* Emulsion serves as a gentle reminder rather than a violent summons. This emulsion of mineral oil with phenolphthalein and an agar-gel permits effective, yet gentle relief through:

1. Replacement of lubricating factors with highly emulsified mineral oil and a colloidal gel similar to mucin in its lubricating properties.
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*Trademark Reg. U. S. Pat. Off.

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second, that doctors of medicine were not competent to testify as to the degree of care and skill required to be used by a chiropractor in treating a patient. In other words, the defendant relied on the general rule, for which there was considerable authority.

In reviewing the case the Supreme Court had this to say about the rule on which reliance was had by the defendant,

"That rule is not applicable in view of the real issue in this case. Plaintiffs do not claim there was malpractice on the part of the defendant while Beherns was engaged in the practice of chiropractry by chiropractic manipulation or adjustments of the spine. Instead, plaintiffs contend there was malpractice when he and his associates went beyond the practice of chiropractry and entered into the general field of the practice of medicine, by the application of the bandage to the foot and by giving in conjunction therewith, the diathermo heat treatments, neither of which was the practice of chiropractry by chiropractic manipulation or adjustment of the spine. On the contrary, the application of the bandages and the heat treatments given in this case are part of the general practice of schools of medicine, and, in so far as there was thus an invasion of the general field of that practice, the methods thus used by defendant's employes in diagnosis and treatment were subject to the rules applicable in the practice of medicine and surgery. Janssen v. Mulder, 232 Mich. 183, 205 N.W. 159; 78 A.L.R. 701; Joyner v. State of Mississippi, 181 Miss. 245, 179 So. 573, 115 A.L.R. 957; 86 A.L.R. 630. Consequently there was applicable in this case the rule that the considered opinion of a qualified member of the profession of medicine and surgery is competent and proper to determine and testify as to whether or not the treatment given constituted the required degree of care and skill which physicians in good standing in the community usually exercise. When there is such an invasion of the field of medicine by the treatment given, the rule, which confines the inquiry as to the required degree of a practitioner's skill and care to the rules and principles of chiropractry or the particular school of science or medicine to which he belongs, does not exclude the testimony of physicians of the other schools when that testimony bears on a point in relation to diagnosis or treatment as to which the principles of the schools do or should concur. * * * And the fact that chiropractors abstain from the use of words like 'diagnosis,' 'treatment' or 'disease' is immaterial. What they hold themselves out to do and what they do is to treat disease, and the substitution of words like 'analysis,' 'palpation,' and 'adjustment' does not change the nature of their act. Com. v. Zimmerman, 221 Mass. 184, and cases cited on page 189, 108 N.E. 893, Ann. Cas. 1916A, 858. Hence when the defendant assumed to perform that duty he must exercise the care and skill in so doing that is usually exercised by a recognized school of the medical profession."

Recovery by the plaintiff was sustained.

It is interesting to contrast the Wisconsin and Michigan cases. The Michigan court sustained a recovery for malpractice by a chiropractor merely circumvented the old rule without disturbing it. Recovery in the Michigan case was sustained on the theory that the chiropractor was negligent in failing to recognize that the patient was suffering from diphtheria, a disease which he did not profess to treat. In the Wisconsin case, the protective rule was modified by making it inapplicable to situations in which the chiropractor invades the field of medical practice.

It is submitted that the approach employed by the Wisconsin court in solving the problem is not only more reasonable and forthright, but affords patients better protection against malpractice by cultists, who so commonly now are invading a forbidden field.

COMPULSORY HEALTH INSURANCE

The fears and doubts expressed about workmen's compensation, unemployment insurance, and other measures of social security have proved to be without foundation. In the future, when we have succeeded in our struggle for a comprehensive health program for the entire country, we shall be able to say about health insurance, too, that present-day apprehensions and misgivings were groundless.—Senator Robert F. Wagner, U. S. Senate, May 24, 1945.

If the Medical Profession demands its full voice in the making of this program we may be without regrets.

HOME-MADE CARE

(Continued from Page 172)

the Calhoun County Medical Society, back in 1934, launched a county-wide experiment in pre-paid medical care which, despite initial difficulties and setbacks, eventually resulted in the development of the state-wide, private group hospital and medical insurance plan.

The Veterans Administration, as General Bradley frankly acknowledges, is tying in with a program which has long since proved that it is a successful, going concern.

The Calhoun county doctors who grappled with the medical care problem a decade ago could not foresee the unexpected fruits of their initiative; could not envision it as a service to the wounded veterans of a war still several years in the future. But they could see an obvious and glaring community need, and they had the stubborn faith that community initiative could contribute materially to the relief of that need.

That initiative and faith find unexpected vindication in the program announced by General Bradley. And the government's plan for using the facilities of the Michigan Medical and Hospital Services in caring for war veterans argues strongly for preserving such successful, independent health insurance organizations under any national health program which congress may consider.

Community initiative has proved its worth in the past. Given the opportunity, it could continue to do so in the future.—Editorial, *Battle Creek, Enquirer-News,* Dec. 30, 1945.

Political Medicine

EDITOR'S NOTE. The following is published in full, to show our members to what a Doctor of Medicine can degenerate. It was released January 4, 1946. Several holders of USPHS commissions have resigned in protest.

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
Washington 14
(Bethesda Station)

December 10, 1945

TO: All officers of the Public Health Service
Subject: The National Health Program

Enclosed is a copy of House Document No. 380 which is the full text of President Truman's message to the Congress on a National Health Program, a subject of the highest importance to every citizen. The message contains a comprehensive analysis of the health problems of the country and recommendations as to the pattern of legislation to deal with them.

It is a source of particular satisfaction to all of us who labor for the public health advancement that this should be the special subject of a Presidential message. For the first time we have the major elements of a national health policy officially stated in comprehensive terms. This has been a goal of all public health workers for many years, and the enunciation of such a policy by the Chief Executive gives the Public Health Service definite objectives for its future work.

On the same day as the message was delivered, Senator Wagner introduced (for himself and Mr. Murray) S. 1606 and Representative Dingell introduced H.R. 4730 designed to implement the proposals of the President. In addition, several bills are pending in the Congress dealing with special phases of the President's legislative program. These include the hospital construction bills, the national mental health bills, and the stream pollution bills, each of which would impose substantial additional responsibilities upon the Public Health Service.

The appropriate executive agencies of the Government have been specifically instructed by the President to assist in carrying out his legislative program as presented to the Congress on September 6. The President wrote to the Administrator of the Federal Security Agency on October 4 requesting him "to take primary responsibility for legislative measures necessary to carry out the part of my message (September 6, 1945) outlined in Section 21 concerning a national Health program to provide adequate medical care for all Americans and to protect them from financial loss and hardship resulting from illness and accident."

Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service.

(Signed) THOMAS PARRAN
Surgeon General

SOCIALIZED MEDICAL PROGRAM

The socialized medicine program received a cool reception in the House following showing by insurance industry that 40,000,000 persons already are covered by voluntary health and accident policies—a five-fold increase over 1939.

More than 400 companies now write health and accident insurance. Total premiums in '44 were $525,000,000 for this class of business, exclusive of hospital service policies.

In addition, more than 5,000,000 persons carry prepaid medical care programs, covering hospital and surgical bills. Almost half of the latter group are covered by employer-sponsored plans in industry. Next, 17,500,000 participate in Blue Cross Hospital plans.

Consolidating all these voluntary protection measures, Insurance Economics Society of America concludes that at least half the population insures itself against medical costs; another 40 per cent handle these emergencies on pay-as-you-go basis without hardship.—*Nation's Business*, February, 1946.

UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

State Vocational Rehabilitation is adopting for its clients the uniform fee schedule for governmental agencies set up by the Michigan State Medical Society with the exception that the ceiling for surgical service is to be $75.00 to this Agency. This $75.00 ceiling is the figure set up by the legislature for the Michigan Crippled Children Commission; Vocational Rehabilitation feels that two state agencies purchasing surgical services should have comparable rates for such services.

State Vocational Rehabilitation is glad that such a schedule has been set up for governmental agencies as it does away with a multiplicity of schedules prevailing in the past. It is felt the new schedule will go far in furthering professional relations between the doctors and Vocational Rehabilitation.

REFRESHER TRAINING FOR DOCTORS LEAVING SERVICE

(Continued from Page 168)

ed and who desire to remain in service for a short period of professional duty prior to return to civilian life. These officers are anxious to return to their civilian practices with the advantages of the latest medical knowledge. Due to the tremendous demand for refresher training placed upon civilian medical teaching centers, many of these medical officers have been unable to arrange for refresher training.

The Surgeon General emphasizes the fact that the refresher training is accomplished by a 12-week temporary duty assignment in the professional field of interest at an Army hospital without per diem. Such an assignment will afford the medical officer a period of clinical work under supervision, and excellent opportunities for collateral study of recent advances in medicine, surgery, and neuropsychiatry.

War Medicine

GENERAL MacARTHUR PAYS TRIBUTE TO MEDICAL SERVICE

"War through the ages has demanded in large degree the help of those who practice the art of healing. Never has such need been greater than in the Pacific. Early in the campaign disease presented its most serious threats. Vigorous action has eliminated much of that hazard. The application of old principles and newly devised measures on a magnified scale has assured our advance against the hazards of nature.

"Almost impenetrable terrain and vast distances have not prevented our doctors from pressing close to the enemy line to give the wounded immediate care. Air evacuation reached its highest development in transporting casualties from the field to hospitals far in the rear. New drugs have accomplished miracles in treatment. And in consequence the command has been maintained in a gratifying state of health with the rate of recovery of the sick and wounded unsurpassed.—Douglas MacArthur, J. Mil. Med. in Pacific.

MEDICAL DEPARTMENT PERSONNEL IN ETO GET TOTAL OF 22,304 AWARDS

Medical Department personnel in the European Theatre of Operations have received a total of 22,304 awards between the period of December 7, 1941 and October 1, 1945, including ninety-seven Distinguished Service Crosses and 2,849 Silver Stars, according to a recent announcement by the Office of The Surgeon General.

Enlisted men of the Medical Department received 17,974 of the awards, officers 3,758, and nurses 572.

The 32,000 officers of the medical service in this theatre (not including nurses) received four Distinguished Service Crosses, 196 Legions of Merit, four Clusters to the Legion of Merit, 200 Silver Stars, twenty Clusters to the Silver Star, 304 Soldier's Medals, 2,716 Bronze Star Medals, 308 Clusters to the Bronze Star, three Air Medals, and three Clusters to the Air Medal.

The Congressional Medal of Honor was received by one of the 202,000 Medical Department enlisted men in the European Theatre of Operations. They also received ninety-three Distinguished Service Crosses, sixteen Legions of Merit, 2,646 Silver Stars, 110 Clusters to the Silver Star, 202 Soldier's Medals, 13,779 Bronze Star Medals, 808 Clusters to the Bronze Star Medal, 227 Air Medals, and ninety-two Clusters to the Air Medal.

ARMY DOCTORS MAKE OVER ONE MILLION PHYSICAL EXAMINATIONS DURING OCTOBER

Over 1,250,000 physical examinations of Army officers and soldiers being demobilized in the United States were completed by Army doctors during October, The two thousand Army doctors assigned to separation centers alone completed examinations of 757,433 men during this period. In addition, Army doctors are assigned to other separation offices.

It is the policy of the Army, General Kirk said, to see that every man being released from the service is given the ultimate medical care before returning to civilian life. In addition, he pointed out, in order to speed demobilization, the complete physical examination has been so planned that the average soldier is processed by eight different doctors in one hour from the time the first doctor sees him, provided he has no ailment.

In this chain of medical examinations he is looked over by a dentist, eye specialist, ear, nose and throat specialist, orthopedist, surgeon, urologist, and internist. Finally an over-all medical officer, who has before him the reports of all preceding examinations, including all x-rays and laboratory tests, with the exception of serology, determines his physical condition. If it is necessary the man is referred to a ninth doctor—a psychiatrist.

CRITERIA FOR RELEASE FROM THE ARMY

Major General Norman T. Kirk, The Surgeon General, has announced the following new separation plan which became effective January 1, 1946.

The following specialists in scarce categories will be released with a critical score of 80, continuous service since Pearl Habor, or if the age of 45 has been reached: eye, ear, nose specialists; orthopedic surgeons; and internal medicine specialists.

A requirement of 70 points, 45 months' service, or 45-year age limit will make the following eligible for separation: gastroenterologists, cardiologists, urologists, dermatologists, anesthetists, psychiatrists, general surgeons, physical therapy officers, radiologists, and pathologists.

Plastic surgeons will be eligible for release if they have a critical score of 80, or service since Pearl Harbor, or if they are 48 years of age.

ADVANTAGES OF ARMY CAREER FOR DOCTORS

The advantages of an Army career for doctors and other officers who are appointed members of the Medical Department under the new law authorizing additional officers for the Regular Army were stressed in a statement by Major General Norman T. Kirk, The Surgeon General of the Army.

Under the terms of this recently enacted law, doctors who apply for appointment and meet the requirements will be given commissions in the grades of First Lieutenant, Captain and Major.

The Army expects to attract a competent staff of doc-

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ADVANTAGES OF ARMY CAREER FOR DOCTORS

(Continued from Page 180)

tors who will maintain the high standards which have prevailed during the war in the care of the sick and wounded because there are definite advantages for the professional man who elects to serve in the Army, according to General Kirk.

A professional career offering broader possibilities in a larger field than the practice of the average civilian doctor affords is open to the Regular Army Medical Corps Officers, General Kirk pointed out. The policy of The Surgeon General of making all general hospital centers for certain types of cases and specialty training gives the doctors in those centers exceptionally wide and varied experience.

The Army has been and is now conducting residency-type training which will allow and encourage doctors to advance in their professional qualifications. Opportunities for administrative and field training will also be continued.

It is the policy of The Surgeon General to arrange the training and assignments of Army doctors in a way to help them obtain board certification for specialties from recognized civilian specialty boards. Army fellowships, residencies and special courses are in operation to further this program designed to aid in advancing the personnel of the Medical Department from a professional standpoint. As facilities and opportunity permit, training in recognized civilian institutions will be expanded.

The security assured the Army doctor will appeal to many professional men, the General explained. There is regular income and regular promotion and also retirement pay, which amounts to 75% of base plus longevity pay for the doctor who has served 30 years or who has reached the statutory age limit. If a man is retired for physical disability at any time during his Army career, he will also receive 75% of his pay at time of retirement for the rest of his life. The Army doctor and his family are also eligible for medical care and hospitalization.

The opportunity to serve in foreign countries will appeal to those who are interested in travel. Wherever there are American forces overseas there will be members of the Medical Department to look after the health of the Army.

Under the new law, any doctor, physically and professionally qualified, who has been on active duty in the Army since Pearl Habor, and who is under forty-five years of age, is eligible for appointment in the Regular Army, unless he has been separated from the service under other than honorable conditions.

His grade will be determined by his age, within limits, or his length of service as a commissioned officer in the Army, whichever is the greater factor. No officer will be appointed in a grade higher than the one which he held in wartime.

The following table indicates the grades provided for Medical and also Dental and Veterinary officers selected for appointment, based on actual commissioned service or constructive service (age):

Actual Commissioned Service	*Constructive Service (Age)*	*Grade*
Less than 3 years	25 to 27 yrs. of age, inc.	1st Lieut.
3 or more but less than 12	28 to 36 yrs. of age, inc.	Captain
12 or more but less than 20	37 to 44 yrs. of age, inc.	Major

Medical Administrative and Sanitary Corps officers who are selected will be appointed in the Pharmacy Corps and should apply accordingly. Educational requirements for the Pharmacy Corps may be waived.

The Adjutant General will direct the applicant to a personnel center where he will be given a physical examination and a general survey test and will be interviewed by a board of officers.

Applications must reach the Adjutant General's Office, Washington 25, D. C., not later than March 10, 1946. A formal application made on WD AGO Form 62, 1 November 1945, will be required even if a statement of interest or other form of application has been submitted previously.

Application WD AGO Form 62 can be obtained at any Army installation or unit headquarters or upon written request to the Adjutant General's Office, War Department, Washington 25, D. C.

The applications should be in duplicate. A person on active duty should submit the application in duplicate through his immediate commander. Those not on active duty should apply direct to the Adjutant General, War Department, in Washington, D. C., Attention AGSO-R. Anyone outside the United States should send his application to the Commander of the Theater in which he is located.

NAVY PROGRAM ENDS AT MEDICAL SCHOOL

The naval V-12 program at the Wayne University College of Medicine terminated Saturday, December 22, when the 75 men then enrolled under the wartime schedule were relegated to inactive status.

Although they turned in their Navy uniforms for civilian clothes, it was emphasized that the men may be recalled to active duty with the U. S. Fleet should any of them be unable to continue medical courses either for financial or academic reasons. The V-12 program has been in operation at Wayne University for three years.

MALARIA RELAPSE RATE DECLINING

The hospital admission peak for malaria relapses in the United States was reached in February, 1945, with a total of approximately 6,000 cases, and has been steadily declining since that time, according to a recent announcement by the Army Medical Department.

During 1943, when men began to return from tropical theaters of operations in increasing numbers, the total number of hospital admissions for malaria relapse reached 5,275. By 1944 it had jumped to almost five times that number—28,150, and in the first six months of this year the total was 30,420.

It is believed, however, that the return of troops from malaria-ridden areas will not appreciably affect the downward trend of admissions, for a large proportion of original personnel already has been replaced and returned.

The JOURNAL

of the Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOLUME 45 FEBRUARY, 1946 NUMBER 2

Clinical Manifestations of Rheumatic Fever

Determination of Rheumatic Activity

By Stanley Gibson, M.D.
Chicago, Illinois

THIS RHEUMATIC FEVER Control Conference is one of the many evidences of the increasing interest which is being taken in the subject of rheumatic fever.

Rheumatic fever is a disease of numerous and varied manifestations. In many of the cases the diagnosis is unmistakable and could scarcely be missed by anyone who is at all familiar with the disease. On the other hand there are mild and atypical forms in which the diagnosis is made with difficulty or perhaps cannot be made at all. There are a number of symptoms and signs occurring in the course of rheumatic fever which are peculiar to this disease. There are others which, though present frequently in rheumatic fever, are found in other conditions and do not in themselves justify a positive diagnosis. I believe that there are five phenomena which alone or in combination are diagnostic of rheumatic fever if they appear in typical form. These are polyarthritis, chorea, carditis, rheumatic nodules, and annular erythema. I wish to discuss these briefly in turn.

Polyarthritis is the most frequent and is very often the first evidence of rheumatic fever. In the milder cases there are pain and tenderness in the joints, a number of joints being involved in rapid succession. In the severer cases there are redness and swelling in addition to the arthralgia. Even without treatment the persistence of symptoms in any one joint is likely to be of relatively short duration. Suppuration does not occur. Another feature which is important is the prompt response of pain, tenderness, redness, and swelling to the use of salicylates. Of course there are many other forms of arthritis which may easily be confused with rheumatic polyarthritis. One must consider actual bacterial invasion such as is present in streptococcic, gonococcic, or other acute infections. Perhaps the type of arthritis most difficult to differentiate is rheumatoid arthritis. Oftentimes the child must be observed for a considerable period before the differential diagnosis is certain. Pain in the region of the joints may also occur in syphilis, tuberculosis, leukemia, and sickle cell anemia. Hence one must be cautious in making a diagnosis of rheumatic fever on joint pains alone. However in the typical cases of fleeting pains which are severe and involve a number of joints with a prompt and dramatic response to salicylate therapy one can have a fair degree of confidence in the diagnosis on this basis alone. Furthermore if one can secure a history of an upper respiratory tract infection some two or three weeks preceding the appearance of the joint pains it lends weight to the diagnosis of a rheumatic invasion.

Chorea is regarded by most authorities as a definite rheumatic phenomenon. There are some who will disagree with this view, yet the extremely high proportion of children having chorea who sooner or later show other evidences of rheumatic

Presented at the Michigan Rheumatc Fever Control Conference, sponsored by the Michigan State Medical Society and the Michigan Crippled Children Commission, at Detroit, Michigan, September 19-20, 1945.

fever is proof of the close association. One must, however, be strict in his diagnosis of chorea. Not every child who has involuntary movements of his muscles is necessarily a victim of the disease. It is necessary to consider the complete picture. I feel that true chorea is a syndrome in which there is a definite beginning, with a continuance of symptoms over a period of weeks and months followed by complete recovery. In addition to the purposeless, involuntary movements of the muscles, the extremities, and the face, one must remember that there is an accompanying emotional instability which is a cardinal symptom. In fact it is often a more distressing feature of the picture than are the movements themselves. These patients are unhappy, quarrel with other members of the family, cry on slight or no provocation, and in general show a decided personality change. Chorea differs from other rheumatic manifestations in that in the uncomplicated cases there is no fever, no leukocytosis, and no change in the sedimentation rate. In other words, one is unable either by clinical or laboratory means to demonstrate the presence of infection. Yet microscopic studies have indicated that there are changes in the brain in chorea so that one may regard it as rheumatic brain disease. Perhaps it is because of its being restricted to small areas of the brain and the fact that it is a low-grade reaction that there is an absence of the usual signs of infection.

Heart Complications

Invasion of the heart itself is, of course, the central fact in any consideration of rheumatic fever because it is here that serious and permanent damage may take place. All the structures of the heart, myocardium, pericardium, and endocardium may be involved. The degree of myocardial involvement is not easy to assess, especially in the earlier stages of the disease. The presence of a to and fro pericardial friction rub is the one reliable sign of acute pericarditis. Clinical pericarditis, however, is found in only a small percentage of cases. Valvular damage is present in well nigh 100 per cent of the cases of rheumatic heart disease, and it is chiefly upon the signs produced by valvular damage that a positive diagnosis can be made. Inasmuch as the mitral valve is the one most frequently involved, one gives particular attention to the signs which result from insufficiency or narrowing of this valve. A soft, blowing systolic murmur occurring at the apex with transmission to the left in a child who has previously had a normal heart is strong evidence of involvement of the mitral valve. If, in addition, a mid-diastolic murmur is heard at the apex, the evidence is even more convincing. Finally, if after the process has gone on for months or years one hears a presystolic murmur over this area he can feel sure that permanent damage to the mitral valve has occurred. I know of no acquired condition other than rheumatic fever which produces this definite progression of signs in the mitral valve. In a fair percentage of cases the aortic valve is also involved. Aortic insufficiency is evidenced by a diastolic murmur usually soft and blowing in character beginning with the second sound and usually best heard at about the third left interspace along the sternal margin. Aortic stenosis with a harsh murmur in the first and second right interspaces may occur after a considerable period of time, but it is a late finding and is not often encountered in children. The typical findings of mitral and aortic damage in a child whose heart was previously normal can be considered definite evidence of rheumatic carditis. I do not wish to overemphasize the importance of murmurs. It is well known that the myocardial involvement is apt to be much more important than the injury to the valves and where we see children with very large hearts we feel that the enlargement results chiefly from myocardial rather than valvular injury. Yet in established rheumatic heart disease murmurs are rarely absent and the murmurs such as I have mentioned are important diagnostic aids. It is important that their timing, quality, and location be carefully noted as otherwise they may be confused with functional murmurs or those due to congenital heart disease.

Rheumatic nodules are among the most interesting and important of the rheumatic phenomena. They occur as rather firm, non-tender swellings chiefly at the elbows, knees, ankles, knuckles, along the spinous processes of the vertebrae, and in the scalp. Unless one searches for them they are apt to be missed. The arms and legs must be flexed to draw the skin tightly over the bony prominences at the elbows and knees in order to bring them into view. They occur almost always in conjunction with severe chronic rheumatic fever in which the heart practically always shows definite and often severe involvement. They are rarely seen in acute fulminating cases in which the total duration of the disease from onset to death is only a

few weeks. They are rarely seen in the milder cases in which there is little or no cardiac involvement. They are rarely a diagnostic aid inasmuch as other rheumatic phenomena have usually been in evidence for weeks or months before the rheumatic nodules appeared. They are, however, of prognostic importance inasmuch as they are associated with severe and long-drawn-out active rheumatic heart disease.

A final sign of rheumatic fever which is not usually emphasized and which is important only as an interesting diagnostic feature is the so-called annular erythema. This consists of a thin, pink, wavy line, usually roughly circular in outline, and varying in size from one to several centimeters in diameter. It is distinctly an erythema. There is no elevation of the skin. Within and without the erythematous area the skin is normal. There is no burning or itching. The most frequent location is on the trunk or proximal portion of the extremities. I have never seen it on the face. It is very evanescent in character, appearing and disappearing within the course of a few hours. It usually occurs in the milder rather than the severe forms of rheumatic fever. It is seen in only a small proportion of rheumatic patients but once exhibited in a given individual it is likely to recur at frequent intervals.

There are a number of manifestations which are frequent in the course of rheumatic fever but which are not limited to this condition. Abdominal pain occurs rather often in rheumatic fever and is likely to be a symptom of onset even before joint pains or other frank rheumatic findings are evident. Under such circumstances a diagnosis of appendicitis is usually made. I can recall at least two children on our service who had normal appendices removed at the onset of rheumatic fever. This finding is a very troublesome one inasmuch as a true appendicitis may occur in the rheumatic child and one is in danger of making a mistake on either horn of the dilemma. One can only say that a very careful physical examination with strict attention to point tenderness and localized rigidity must decide whether operation is to be done. Another frequent symptom is fever, usually of low-grade once the acute joint symptoms have subsided. Freedom from fever, however, does not necessarily mean freedom from infection because one sees constantly children with active rheumatic infection with a normal temperature. Precordial pain may occur but it is not usually an important diagnostic symptom. In my experience precordial pain occurs chiefly under two conditions: (1) when there is acute pericarditis; (2) in children with extremely large hearts where symptoms resembling those of angina pectoris may be present. Precordial pain is usually conspicuous by its absence in rheumatic heart disease. Nose bleeds are frequent in children with active rheumatic fever. This may, however, be the result of local pathology in the nose or of other diseases. Pulmonary symptoms sometimes suggestive of pneumonia may occur, but usually in conjunction with recognizable heart involvement. The laboratory findings include anemia, usually moderate in degree, leukocytosis, and an increase in the sedimentation rate. Among other minor manifestations are poor appetite, loss of weight, pallor, fatigue, and headache.

How is one to interpret these various signs and symptoms in relation to rheumatic fever? In the presence of some actual rheumatic phenomenon such as polyarthritis or heart disease, these findings merely serve to fit in to complete the clinical picture. I do not feel that any combination of these findings which I have just mentioned is sufficient to make a positive diagnosis of rheumatic fever. One of the most common diagnostic problems with which a pediatrician is confronted is that of the child who has a little fever, tires easily, is losing color, perhaps has a poor appetite with slight loss in weight together with some nondescript pains in his extremities and possibly a faint murmur over the heart.

When one reviews this group of symptoms he readily recognizes that disease entities other than rheumatic fever can match practically all of them. A good example is tuberculosis. Another is the prolongation of the active stage of an upper respiratory tract infection due to a focus of infection somewhere in the body. A fair number of children with such symptoms as those mentioned have sinus infection. It is necessary, therefore, to view these symptoms as confirmatory rather than as occupying an important place in the symptomatology of rheumatic fever. An unexplained fever or epistaxis or easy fatigability would readily raise the question of rheumatic activity in a child who had previously had an out and out rheumatic fever. On the other hand one would not be justified in making such a diagnosis if the symptoms were present for the first time.

At this point I wish to warn against the diagnosis of rheumatic fever, and particularly of rheumatic heart disease, on insufficient evidence. The great interest which is now being taken in this subject will cause all physicians to be increasingly alert to the possibilities of such a diagnosis and lead them in their enthusiasm to suspect it in instances where they might not otherwise have done so. We are all familiar with cases in which such a diagnosis has been made and in which subsequent events would indicate that it has been made in error. The laity has a justifiable fear of heart disease because they know of its ability to maim and to destroy. To mention to a mother that her child has a heart murmur even though in the same breath one states that the murmur is functional and of no significance is apt to cause her to leap to the conclusion that something terrible is going to happen. If one physician makes a positive diagnosis of heart disease which is refuted by half a dozen other physicians she still has the lurking fear that the one who first made the diagnosis is correct. I believe it is perfectly logical to raise the question of rheumatic fever and to state that the child must be kept under observation and that in the course of time a definite answer can be given. I have seen a number of instances in which both the parent and the child have practically become chronic invalids because of an injudicious remark concerning the heart by their physician. It is better to err on the opposite side and withhold a positive diagnosis until one is on firm ground.

The determination of activity of the rheumatic infection is one of the most difficult problems in connection with the entire subject of rheumatic fever. It is of first-rate importance because management is determined by the presence or absence of active infection. The presence of rheumatic polyarthritis is, of course, evidence that active infection is going on. The presence of rheumatic nodules is also an indication of active infection, particularly if new crops are appearing, although in some instances a few nodules may remain when there is no other sign to indicate activity. Annular erythema is also usually regarded as evidence of activity. In the presence of established heart disease one may not be able by auscultation of the heart to say whether active infection is present or not. Naturally, the appearance of a pericardial friction rub, the development of a new murmur, or a distinct change in murmurs already present may enable one to say that changes due to active mischief are occurring in the heart. More often than not the findings in the heart remain practically the same over considerable periods regardless of whether activity is present or has subsided. It is to the so-called minor phenomena which we have mentioned that one must turn for signs of activity. Unexplained fever is significant, although as I have already stated the absence of fever does not necessarily mean that convalescence has begun. Secondary anemia, leukocytosis, loss in weight, anorexia, nose bleed, and easy fatigability are in the proper setting indicative that active infection continues. All of these symptoms may subside, however, before the termination of the active process. Perhaps the one most dependable sign is the sedimentation rate. It is well known that it may remain rapid after all other manifestations have disappeared. It is usually looked upon as the one best criterion for determination of the absence or presence of rheumatic activity. It should not be forgotten, however, that the sedimentation rate may be normal in the presence of congestive heart failure. So far as I know there is no complete agreement as to the normal limits of variation of the sedimentation rate. I have seen a number of children who have done well following active rheumatic infection in whom the sedimentation rates were somewhat higher than the usually accepted standards. Moreover the technique is sufficiently exacting that one should not accept without mental reservation a sedimentation rate done by the newest intern on the service. It will also be found that the sedimentation rate may vary considerably from day to day. Too great dependence should not be placed on the result of a single test. As a matter of practical fact in discharging our rheumatic patients from the hospital ward we utilize a number of criteria. First of all, we are anxious to know that the patient has been free of fever for some time, that his appetite is good, that he is recovering from his anemia, that his white count is normal, that he is gaining in weight, and that he has that look of interest and alertness which indicates a state of well-being. Secondly, we wish to know that the sedimentation rate is at least within the upper limits of normal. And finally, I always ask the head nurse on the ward whether she thinks the child is able to go home. She is the one who observes him from morning

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Rheumatic Heart Disease

The Use of X-Ray in Diagnosis

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ROENTGENOLOGY has played an increasingly important role in the study of cardiac abnormalities ever since Williams'[11] early observations made less than one year following Roentgen's momentous discovery in 1895. Important advances in conventional roentgenologic apparatus and technique, supplemented by the development of orthodiagraphy, teleradiography, laminagraphy, photofluorography, cineradiography, and contrast angiocardiography, have all served to place cardiac diagnosis upon a progressively more scientific basis. There is no question that as a direct result of these improvements, the roentgenologist has acquired added responsibility in the identification of various cardiovascular lesions. Without further delay, however, it should be emphasized that despite the significant advancement of roentgenology as a diagnostic agent, the time-honored clinical methods of investigation have not been materially altered. Careful correlation with clinical findings is necessary in nearly all instances where roentgen examination is employed. As to relative importance in cardiac diagnosis, it is generally agreed that, with few exceptions, roentgenology belongs in the fourth position, ranking well behind a carefully elicited clinical history, a thorough physical examination, and electrocardiography.

All of these generalities are applicable to rheumatic heart disease which is the type most frequently seen by the roentgenologist. Since all of the above-mentioned roentgenologic procedures have been employed at one time or another in the study of that disease, a brief description of each seems warranted.

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Presented at the Michigan Rheumatic Fever Control Conference, sponsored by the Michigan State Medical Society and the Michigan Crippled Children Commission, at Detroit, Michigan, September 19, 1945.

Fluoroscopy, which consists of the direct visualization of the shadow of the heart on the fluorescent screen, is of prime importance in cardiac diagnosis. By such procedure, the observer may choose the optimum degree of rotation in which to study the various cardiac chambers in different disease conditions. He may separate these salients to a considerable degree by discerning characteristic auricular and ventricular pulsations. Abnormal pulsations and changes in cardiac movement during different phases of respiration may be noted. The all-important relationship of the heart to its adjacent structures may be carefully studied. With justice it may be stated that no individual unskilled in fluoroscopy should attempt diagnosis of cardiac lesions by roentgenologic means.

Orthodiagraphy is a fluoroscopic method of determining heart size which eliminates distortion by the use of a non-divergent central x-ray beam. Using this perpendicular beam, a tracing of the cardiac silhouette is made and transferred either directly or indirectly to a sheet of paper which serves as a permanent record. In the hands of an experienced fluoroscopist, this method affords the most accurate measurements of heart size. But, as in any fluoroscopic procedure, the personal equation is an important factor and considerable variation may be found in the results of different observers. Another disadvantage is that special fluoroscopic equipment is required.

Distortion and magnification of the heart shadow due to the inevitable divergency of an ordinary x-ray beam may also be largely overcome by increasing the distance between the source of radiation and the heart to six feet or more. It is technically impracticable to operate a fluoroscope under such conditions, but films may be readily and rapidly exposed. Such films are called *teleoroentgenograms.* They constitute a more accurate record of the cardiac status, and show the relation of the heart to surrounding structures in greater detail. There is a tendency among technicians to expose teleoroentgenograms in full inspiration, giving a cardiac shadow which may be very misleading. If the exposure is made with the patient holding his breath in mid respiration, the resultant film will show a more accurate representation of both cardiac size and shape.

It should be obvious that a combination of orthodiagraphy and teleoroentgenography most closely

approach the ideal in the determination of heart size. What must not be forgotten is that, at best, this combination is merely an approximation. The roentgenologist's computations may be expressed in millimeters, but this is entirely a relative matter.

Kymography, a method of examination which by utilizing a moving grid of lead strips yields a graphic representation of cardiac movement, has been on the whole somewhat disappointing. In our hands it finds its greatest use in recording the improvement of cardiac pulsation following surgical treatment of chronic constrictive pericarditis.

Laminagraphy, or body section radiography, as it is frequently called, permits segmental examination of various portions of the thoracic cardiovascular structures. At first thought, such procedure appears to have great advantages but unfortunately the various portions of the heart and the blood within them produce identical x-ray shadows as far as density is concerned. Thus, very little information is gleaned from these roentgenographic sections of the heart that cannot be acquired by simpler methods.

Photographing the fluoroscopic image of the chest with an appropriate still camera for survey purposes, *photofluorography,* is a procedure which at the present time is riding the crest of a tremendous wave of popularity throughout the country. Such mass radiography of the heart and lungs gives us a splendid opportunity to observe first-hand the great variation in the size and shape of the normal heart, and as a result to better evaluate the abnormal.

Recording the fluoroscopic image of the heart with a moving picture camera is known as *cineradiography.* This method has been in its "incipient" stage for a good many years, but considerable progress has been made recently. We may reasonably expect early perfection of this diagnostic medium which should illustrate cardiac dynamics in a more detailed manner than has been previously possible by any other method.

In 1938, Robb and Steinberg[5] described a method of visualizing the various chambers of the heart and great vessels by peripheral intravenous injection of *contrast material* (70 per cent diodrast). While it is comforting to know that this truly significant achievement is available when other diagnostic measures fail, it should not be regarded as a simple procedure to be used indiscriminately.

Before proceeding to the practical application of these roentgenologic methods in evaluating the various manifestations of rheumatic heart disease, the following points should be clearly kept in mind:

1. The roentgenologist diagnoses disease of the heart by alterations in its size, shape, position, movements, and consistency of shadow from accepted normals which under all circumstances show wide variations.
2. If a patient is suspected of having heart disease, unequivocal x-ray evidence of cardiac enlargement serves as adequate proof of that suspicion. The converse is not true. Serious cardiac abnormalities may exist in a heart that is roentgenologically negative.
3. The most important contribution of roentgenology in cardiac diagnosis is the confirmatory evidence it supplies to clinical findings which are already apparent. On occasion, clinically unsuspected abnormality is discovered by x-ray methods, but the majority of such instances are due to initial oversight on the part of the referring physician.

Rheumatic Valvular Lesions

Mitral Valve.—The characteristic roentgenologic feature of mitral valve disease is enlargement of the left atrium. Sosman[7] states that this applies equally to mitral stenosis and mitral regurgitation, but the latter produces associated left ventricular enlargement, whereas in stenosis increased pressure in the pulmonary circulation produces enlargement of the right ventricle. Demonstration of the enlarged left atrium in mitral stenosis is second in importance only to the typical diastolic murmur[3], and fortunately this enlargement can be identified in the great majority of instances.

It cannot be emphasized too strongly that, as a rule, left atrial enlargement cannot be seen to best advantage in the conventional frontal projection of the heart. The normal left atrium is situated posteriorly, and when viewed in the sagittal plane only the auricular appendage can be seen along the left heart border. Much of the atrium is actually situated to the right of the mid line. When it enlarges it does so in a posterior direction so that it shows up to best advantage in the right anterior oblique or lateral projection, par-

ticularly when the degree of enlargement is slight. Rigler[4] has emphasized the fact that a dilated left atrium displaces the esophagus posteriorly and to the right so that a swallow of barium showing this displacement may assist in the diagnosis. As enlargement of the atrium continues the middle third of the normally air-containing posterior mediastinal space may be obscured and the main bronchi may become spread farther apart. Both of these signs are likewise best seen in the right anterior oblique position.

Viewing the heart from in front, one may observe four distinct convex curves along its left border. The uppermost prominence is that of the aortic arch which frequently appears hypoplastic. Real hypoplasia supposedly occurs when mitral disease is acquired in childhood; it is thought to be due to a decreased volume of blood from the left ventricle which in turn is due to the stenosed mitral valve. Sometimes the hypoplasia is apparent rather than real as the result of relative dilatation of the pulmonary artery which forms the second bulge directly beneath that of the aorta. The third convex curve is the border of the enlarged left auricle, and the lowermost is that of the left ventricle. These four prominences constitute so-called "mitralisation" of the heart, a term which is very popular but quite unreliable and generally unsatisfactory. Congenital heart disease, thyrotoxicosis, extensive pulmonary fibrosis and several other conditions may at times produce "mitralisation." The same configuration is even seen occasionally in certain individuals of asthenic habitus without any of the abnormalities listed above. Furthermore, in infants and young children slight rotation of the chest or changes in intrathoracic pressure due to crying may produce apparent broadening of the waist of the heart which might easily be mistaken for the changes in mitral disease. Great caution must be exercised in evaluating chest films in children or many false positive diagnoses of cardiac abnormality will be made.

A more important roentgen sign of mitral stenosis seen at times in the frontal view is a double convexity of the right heart border resulting from an overlapping of the right atrial shadow by the enlarged left atrium. The left atrial shadow is higher in position, although at times it may become so prominent as to form the entire right heart border. The explanation of this lies in the fact that the spine limits the posterior enlargement of the left atrium and as dilatation progresses the atrium somewhat paradoxically slides off into the right lung field. We have seen one patient in whom the right border of a tremendously enlarged left atrium actually extended to the right lateral chest wall.

Careful fluoroscopic search for calcification in the mitral valve should always be made since it is relatively common and, if found, represents conclusive evidence that stenosis is present. No special equipment is necessary but dark adaptation of the observer's eyes must be complete. This means that the fluoroscopist should spend at least twenty minutes in complete darkness before the examination is begun. The calcified valve appears as a dark, elliptical shadow with a characteristic dancing movement, the speed of which depends upon the heart rate. Once again the optimum position of the patient is the right anterior oblique.

Sosman[8] warns that calcification in the mitral valve must be differentiated from a calcified mitral annulus fibrosis which is purely a senile change analogous to arcus senilis. The calcified annulus is larger, more homogenous, and U or J-shaped in appearance.

Practically all cases of mitral stenosis eventually show some degree of pulmonary vascular congestion, the roentgenologic manifestations of which frequently are recognizable before clinical signs are apparent. The hyperemia is usually bilaterally symmetrical although exceptions are encountered. Care must be taken to differentiate pulmonary congestion from widespread fibrosis or pneumonitis.

Aortic Valve.—The roentgen findings in patients with aortic valvular disease are not nearly as conclusive as they are in cases of mitral stenosis. Much has been written about the so-called aortic configuration but this is certainly not diagnostic of either rheumatic aortic insufficiency or aortic stenosis, it being frequently encountered in both hypertensive and luetic heart disease.

In aortic insufficiency one may observe marked enlargement of the left ventricle and vigorous pulsation corresponding to the well-known water-hammer pulse. The aorta is more prominent than normal. Fortunately the clinical diagnosis of uncomplicated aortic insufficiency is relatively easy, and the roentgenologist is seldom called upon for diagnostic aid.

On the other hand, the clinical diagnosis of aortic stenosis is difficult according to the figures of Thompson and Levine.[9] These authors state that in general practice the diagnosis is made in only 40 per cent of the cases and by experienced cardiologists in only 53 per cent. Thus the field for roentgenologic help is wide open, but unfortunately there is little about the size, shape, and action of these hearts with aortic stenosis that can be considered characteristic. Points favoring a diagnosis of aortic stenosis are only slight enlargement of the left ventricle and less forcible but more sustained pulsation of both ventricle and aorta than is the case in aortic insufficiency.

One really important roentgen finding in aortic stenosis is calcification of the valve. Sosman[7] declares that the great majority of stenotic aortic valves seen at autopsy contain large calcium deposits. He claims further that most of these concretions (90 per cent) are demonstrable fluoroscopically and, if found, invariably denote stenosis of rheumatic etiology. To differentiate aortic from mitral valve calcification fluoroscopically, the patient is turned into the left anterior oblique position. Under such circumstances the mitral valve is in the posterior third of the heart shadow and the aortic valve is in the middle third, closer to the base and higher in position.

Combined Mitral and Aortic Valves.—A combination of mitral stenosis and aortic insufficiency is more common in rheumatic heart disease than either valvular abnormality by itself. It is in these combined lesions that we see unusually large hearts, the classical cor bovinum. Since the mitral lesion usually develops first, the roentgenographic appearance of the heart is predominantly that of mitral disease with broadening of the waist of the heart and posterior enlargement of the left atrium. The aortic knob, however, is broad rather than diminutive and the left ventricle may be extremely large. Frequently the shape of the heart is not typical and a definite roentgenologic diagnosis is not possible.

Tricuspid and Pulmonic Valves. — Rheumatic lesions of the tricuspid and pulmonic valves occur almost invariably in conjunction with mitral or aortic lesions. The clinical interpretation of these right-sided valvular lesions is notoriously inaccurate, and roentgenology has very little to offer in the way of precise diagnostic signs.

Pericardial Lesions

In acute rheumatic pericarditis, there are usually no recognizable roentgen signs. Pericardial effusion, however, may occur relatively early in the disease process and it is generally under such conditions that roentgenologic confirmation is sought.

It has been estimated that at least 250 c.c. of fluid must be present in the pericardial sac of an adult before radiographic detection is possible.[6] In children, of course, the critical level is considerably lower, being closer to 50 c.c.

The earliest recognizable roentgen sign of pericardial effusion is distention of the posterior inferior recess due to gravitation of the fluid to the base of the pericardial sac. This finding is observed only in a lateral view of the chest. As fluid accumulates the cardiac silhouette may show rapid increase in size in all projections, a most valuable finding that clearly indicates the need of frequent interval examinations. Children in particular are prone to develop sizable rheumatic pericardial effusions which may be absorbed as rapidly as they appear.

Depending largely upon the amount of pericardial fluid present, the frontal view of the heart may show it to be either triangular or globular in shape. If the patient is placed in a prone position with the head lowered, the effusion will sometimes shift superiorly producing visible broadening of the waist of the heart. Pulsations will be uniformly diminished or entirely imperceptible.

The old idea that the lateral cardiophrenic angles lose their acuteness in pericardial effusion has been largely disproved by roentgen methods. Only when the diaphragm is abnormally high in position are obtuse cardiophrenic angles observed.

It is apparent that x-ray examination may be extremely helpful in the diagnosis of pericarditis with effusion but it is far from infallible. A markedly dilated heart may simulate all of the findings described above and make differentiation impossible unless exploratory puncture is employed.

White[10] maintains that he has never encountered a case of chronic constrictive pericarditis of rheumatic etiology but, as Levine[2] points out, a great many of these cases remain unclassified and there is reason to believe that rheumatic fever may prove to be the origin of at least some of them. The condition is relatively uncommon, but since it is one of the few types of heart disease which can

be helped surgically we should be on the lookout for it at all times.

Although the clinical findings in constrictive pericarditis are usually diagnostic, roentgenologic examination is always indicated when surgery is contemplated. The heart is frequently found to be strikingly triangular in shape and relatively small. The aortic knob is either absent or flattened.[1] Fluoroscopy is most valuable, showing diminished pulsations over the portions of the heart involved and limitation of lateral shift of the heart with changes in position of the patient.

Demonstrable calcification in the pericardium is a pathognomonic sign of adhesive pericarditis. It can be found in approximately 50 per cent of cases, but its presence does not always denote constriction of the heart. Heavily exposed lateral and oblique films usually show the calcium to best advantage.

Summary

An attempt has been made to show that roentgenology is a valuable adjunct to other well-established methods in the diagnosis of rheumatic heart disease. Demonstrating a selectively enlarged left auricle is a most reliable sign in mitral disease, and finding calcification in the aortic valve is virtually diagnostic of stenosis of that structure. Valuable confirmatory evidence of other valvular lesions and certain forms of pericarditis may also be obtained by careful roentgen examination.

On the other hand, a great many instances of rheumatic valvular disease of all types produce no characteristic x-ray appearance, and at times it is impossible to differentiate pericardial effusion from pronounced cardiac dilatation. Furthermore, the normal thoracic cardiovascular shadow is subject to such individual variation, especially in children, that not infrequently cardiac abnormalities may be very closely simulated.

If we thoroughly appreciate the true value, and particularly the distinct limitations of roentgen methods in the recognition of rheumatic heart lesions, case-finding will be facilitated and many of the false positive diagnoses which we have reason to fear will be averted.

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MSMS

CLINICAL MANIFESTATIONS OF RHEUMATIC FEVER

(Continued from Page 196)

until night. She knows of his eating habits, of his general behavior, and of his small complaints which the attending physician who has spent only a short time with the child is never able to evaluate.

There are a number of cases which after careful evaluation of all of the criteria we possess still leave us in doubt. We feel that under such circumstances conservatism is the only proper course to follow. A few more weeks or months in bed is not of grave consequence in the life of a child. To allow him up too soon when activity may increase damage to the heart is a serious mistake.

Summary

1. The phenomena which are an integral part of rheumatic fever consist of polyarthritis, chorea, heart disease, rheumatic nodules, and annular erythema.

2. There are many phenomena associated with rheumatic fever but which are not necessarily diagnostic, such as fever, pallor, poor appetite, loss of weight, easy fatigability, abdominal pain, precordial pain, nose bleeds, anemia, leukocytosis, and increased sedimentation rate.

3. Brief mention has been made of the symptoms and signs which determine activity of the rheumatic infection.

Arizona, Colorado, New Mexico, and Utah, are the only four states of the Union, every one of which touches the other.

Chorea

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THE INCLUSION of chorea in the rheumatic syndrome has been questioned largely because of the relatively low incidence of a complicating carditis.[1] The conflicting evidence is well reviewed by Jones and Bland[2] who present their own experience with nearly 500 cases followed over a significantly long period of time and compare them with about an equal number of patients with manifestations of rheumatic fever other than chorea. I can do no better than quote their conclusions with which most of us agree:

"Over . . . eight years, 72 per cent of patients with chorea exhibited other manifestations of rheumatic fever, while in 28 per cent only chorea was found. The incidence of rheumatic heart disease in the groups of patients studied was 86 per cent in the group with rheumatic fever without chorea as compared with 54 per cent with chorea. When the group of patients with chorea were further analyzed into (1) those with chorea and other manifestations of rheumatic fever, and (2) those with chorea but no other manifestations of rheumatic fever—(so-called "pure chorea"), the incidence was found to be 73 per cent and 3 per cent respectively. Therefore, chorea is considered to be a mild manifestation of rheumatic fever and in itself not especially conducive to the development of heart disease."

Chorea occurring alone, then, carries with it a small chance of a complicating carditis, though in the experience of Sutton[3] and in our series of seventy cases, the incidence was higher than that of the Boston group (20 per cent in the New York series, and 10 per cent in ours). In Sutton's series the child who began his career with chorea ran a 50 per cent chance of developing some other manifestation of the rheumatic syndrome.

Our experience with this condition derives from two different types of material. Our first four years' training covered experience in the dispensaries of hospitals in New Haven, Boston and St. Louis, exclusively charity patients. For nearly twenty years since that time, we have worked in an active clinic, drawing its material largely from the middle economic stratum. There have been about a quarter million visits to this outpatient clinic in that time. Some of these are single visits with no follow-up; a larger percentage represent patients born in the hospital and supervised from birth on. In the twenty years there have been seventy-one cases of chorea seen. We have never seen a case in a child born in the clinic and followed regularly from birth. This point I think is significant and I shall refer to it later.

Of the seventy-one cases seen, forty-two had no joint manifestations of rheumatic fever; seven (10 per cent of the total number) have developed carditis without joint manifestations. Of those showing joint disturbances, in addition to their chorea, 80 per cent showed evidence of carditis also.

Differential Diagnosis

The clinical picture of chorea is so bizarre that there would seem little likelihood of confusing it with anything else, and I think this is usually true. Well developed, the picture may be described as an uncontrollable, purposeless athetosis. Occasionally, mild cases pose the problem of differentiation from habit spasm and tics. Involvement may at times be slight enough to escape detection for a long time. One youngster sent from a private school must have had trouble for months before his teachers detected awkwardness in his writing, because he said that during that time he had "lost his stuff" on the pitching mound and lacked control. It is just this sort of co-ordinated movement that fails first. Awkwardness in the handling of a fork or a pencil, involving as these acts do the synchronous movement of several muscles, may first call attention to the difficulty. With the problem in mind, I usually ask the child to shake hands; his grip is unevenly sustained. I have him write his name in the record and here a lack of control may be very evident. Asked to smile, his response is abrupt, but equally abruptly he may resume a masklike expression. Asked to show his tongue, he may bite it in attempting to control it. Patients with well-developed chorea seldom talk. A certain percentage of our cases have shown definite signs of increased intracranial pressure with fulness of the retinal vessels and a bradycardia. One

Presented at the Michigan Rheumatic Fever Control Conference, sponsored by the Michigan State Medical Society and the Michigan Crippled Children Commission, at Detroit, September 19-20, 1945.

case showed marked signs of meningeal irritation with a definitely increased pressure in the spinal fluid, no increase in cells but an elevated sugar. The choreiform movement did not appear until his second day in the hospital. Incidentally, in this child there unfolded the complete rheumatic picture: polyarthritis, erythema nodosum and multiforme and a pancarditis. A sedimentation rate may be helpful in differentiating the mild case from a habit spasm, but we agree with Sutton that it may frequently be normal in true chorea.

Treatment

In a disease as variable in severity and duration as chorea, and, in its pure form, carrying with it so small a chance of a complicating carditis, the results of treatment are difficult to evaluate. So striking, however, was the reduction in complications in Sutton and Dodge's follow-up of patients treated with fever induced by triple typhoid vaccine that we have felt it a duty to recommend this to all suitable cases. We have not used it when there was evidence of active carditis. Of twenty-five who received it, five developed carditis, but all of these had joint manifestations of rheumatic fever as well. In a few cases showing evidence of increased intracranial pressure: papilloedema and bradycardia, hypertonic glucose has seemed to have value. The Kettering hypertherm was tried but discontinued when it seemed to represent an exhausting experience, physically and emotionally. We have followed the detailed technique outlined by Sutton and Dodge except that we have given treatments on alternate days rather than successive ones.

Prophylaxis

In any infectious disease process there are always at least two variables, the seed and the soil. The story of the activation of latent tuberculosis by nutritional deficiency is an old one and is being re-told in Europe at the present time. One of the most striking examples occurred in Denmark following the first world war. Denmark had shared the marked rise in the incidence of this disease with the rest of the countries who were ill fed, but when the removal of her dairy products by Germany was suddenly prevented, an almost dramatic fall in rate followed.

The repeatedly noted unequal distribution of the rheumatic state in the various economic classes, in spite of the almost universal presence of the offending streptococcus, the increase in the prepuberty period when the demands of rapid growth are so commonly not met, with an equally striking fall when the growth process has ceased—all of these have led to a more critical evaluation of the soil. A failure to influence significantly the developed rheumatic state by alterations in diet does not appear to us to be particularly pertinent. A similar failure was noted with well-developed tuberculosis.

In Marshall's series of 180 cases only eight cases of rheumatism and carditis occurred in his upper economic group, and one of chorea and carditis. Warner's careful dietary study showed a low intake of milk in the affected group . . . "perhaps the most striking fact suggesting that an increase in animal fat in the form of fresh milk and butter may be of prophylactic value is furnished by the figures from Christ's Hospital where the incidence of rheumatism was reduced to less than a third corresponding to a rise in the animal fat consumption from 50.6 to 103.6 gm., due largely to an increase in the rations of milk and butter." Of course, this carries with it a doubling of the calcium intake. Warner noted that concentrates of vitamins A and D did not accomplish the same thing. In Coburn and Moore's study, the poor diets were not low in a single component but in many, notably protein, calcium, iron and vitamin A.

My own experience, quoted above, of failing to note chorea in any child whose nutrition has been supervised from birth, and of seeing an abortive form of the rheumatic stage in general in a small percentage of the entire group has made me feel that the contribution which the medical profession has to make to this whole problem may be the largest in the prevention of malnutrition. This is a problem in which dietetics *per se* plays only a fractional role. In the lower strata the problem is one of economics. In the middle and upper strata, it is in part one of our imperfect knowledge of nutritional requirements, but in our opinion, it is more largely a medical one. In a study of 100 children, whom I considered poorly nourished, who had come from good homes, the diet offered seemed to play a role in less than 5 per cent; in the others the highest percentage presented some condition interfering with the utilization of food, and high on the list was the in-

fected tonsil. I hold no brief for tonsillectomy as a specific help in the rheumatic state and agree with Wilson whose analysis of over 1800 cases from the literature led her to this statement: "Evidence which is available does not lend support to the view that rheumatic fever *per se* is an indication for the removal of tonsils . . . it is probable that the value of tonsillectomy in rheumatic children is proportionate to its influence on the general health of the child. The criteria for tonsillectomy in such children should not differ from those followed for tonsillectomy in the non-rheumatic child." One of those criteria on which we rely most is the occurrence of malnutrition in a child being offered an adequate diet and showing a persistent cervical adenitis. We were able to study the nitrogen balance on a group of such children before and after tonsillectomy. On an intake of protein as high as we could get the child to take, the retention of nitrogen rose from 0.06 gm. per day before to 1.52 gm. per day after the procedure. This type of defect is definitely not detected by dietary surveys. In the calcium field, we feel that neither the need for vitamin D nor the amounts of calcium necessary for growth are appreciated in the child approaching puberty. In the twelve-year-old girl, amounts of calcium just short of 1.3 grams without added vitamin D actually gave negative balances at a period of growth when normally as much as 500 mg. a day may be stored. Nor do we feel that there is a general appreciation of the high protein requirement of the adolescent. Measuring this, we found that consistently positive nitrogen balances were obtained only when 15 per cent of an otherwise adequate caloric intake was derived from protein. We found further that the child's appetite for it was a good guide to the amount; this is important when one hears so frequently from mothers the statement that "of course I don't let him have too much meat." We could not persuade children to take too much. Ninety grams of protein (15 per cent of 2600 calories) would mean the protein from a quart of milk, two eggs, a serving of cheese and two chops, or their equivalent. In one study it was evident that the father, whose requirement is negligible, might obtain that much but not his child. Another item deserving equal attention is the influence on retention of various glandular abnormalities. In the time allotted, I merely mention them to point out that they represent factors influencing utilization rather than intake, and therefore are not included in assessments which assume that an adequate diet implies adequate nutrition.

I mention these as a few of the things affecting normal nutrition which in turn may condition the development of the rheumatic state.

Summary

We feel that chorea is a mild manifestation of the rheumatic state; that uncomplicated by joint manifestations, the likelihood of carditis is small. We feel that the treatment of the active state at present is best accomplished with fever therapy induced by triple typhoid vaccine. We feel that its development is largely conditioned by a poor nutritional background, and that our chief contribution as physicians lies in our insuring normal nutrition, not only by intelligent provision of the requirements for growth, but also by a careful exclusion of those things which interfere with the utilization of food.

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The Influence of Light upon the Pituitary Gland and Its Functions

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ENDOCRINOLOGY CAN be related to almost anything, and since this brief paper has to do with light and the pituitary gland, I quote from the Bible.

1. In the beginning God created the heaven and the earth,
2. And the earth was without form, and void; and darkness was upon the face of the deep. And the Spirit of God moved upon the face of the waters.
3. And God said, "Let there be light," and there was light,
4. And God saw the light, that it was good; and God divided the light from the darkness.
5. And God called the light Day, and the darkness He called Night.

Now if you will bear with me just a little longer before getting into the text, I wish to quote from Langdon Smith's "Evolution."

"When you were a tadpole and I was a fish
In the Paleozoic time,
And side by side on the ebbing tide
We sprawled through the ooze and slime
Or skittered with many a caudal flip
Through the depths of the Cambrian fen,
My heart was rife with the joy of life,
For I loved you even then.

Mindless we lived and mindless we loved
And mindless at last we died;
And deep in the rift of the Caradoc drift,
We slumbered side by side.
The world turned on the lathe of time,
The hot hands heaved amain,
Till we caught our breath from the womb of death
And crept into light again.

We were amphibians, scaled and tailed,
And drab as a dead man's hand;
We coiled at ease 'neath the dripping trees
Or tailed through the wind and sand.
Croaking and blind, with our three-clawed feet,
Writing a language dumb,
With never a spark in the empty dark
To hint at a life to come.
And that was a million years ago
In a time that no man knows;
Yet here tonight in the mellow light
We sit at Delmonico's.

Then as we linger at luncheon here
Oe'r many a dainty dish,
Let us drink anew to the time when you
Were a tadpole and I was a fish."

From the Department of Internal Medicine Harper Hospital. Read before the Detroit Academy of Medicine, November, 1943.

The beneficial influence of sunshine was recognized long ago by ancients and was incorporated into rites of sun worship by many tribes both ancient and modern. Haeckel[8] in his "Riddle of the Universe" was of the opinion that sun worship was a more logical form of religion than any other. The multitude of uses the sun rays have been put to are well known. Science and specifically medical science has made great use of the sun rays for their therapeutic benefits.

Not a great deal is known, however, as to how this modality achieves the influences and benefits which it does. This brief presentation deals with the influence of light on the pituitary gland and its functions. Both American and European investigators have studied the varying hormonal content of this gland as influenced by light and darkness. It has been known for sometime that if the posterior lobe of the frog pituitary is removed, the animal becomes silvery white and the restoration of its normal color is achieved by the administration of posterior lobe extract. It has been shown that the pars intermedia of the pituitary contains the melanophore stimulating hormone. The frog is unable to undergo the normal color changes adapted to its environment when either the eyes or the pituitary gland are removed. There is, therefore, a physiological, chemical and anatomical connection between the eyes and the pituitary. The anatomical connection has been shown by Pines[11] and Greving.[7] They discovered the tractus hypophyseus-supraopticus. This tract establishes a direct connection between the optic nerve, the nucleus supraopticus and the pituitary. Both cold and warm blooded animals possess this tract. Greving has expressed the opinion that in cold blooded animals the regulation of color changes is a function of this tract.

Jores[9] showed that the melanophore changes in the frog are abolished if either the eyes or the pituitary is removed. He found that the blood and the eye of rabbits contained increased amounts of melanophore stimulating hormone during periods of darkness but that the amount was decreased in the pituitary. Darkness leads to discharge into the blood stream, light produces a storage or appearance in the gland. If frogs are blinded and their optic nerves not stimulated, the animals behave like those in the dark, but if the optic nerves are stimulated electrically (sensation-like light) or directly by light, the animals act

like lighted ones. Rodenwald[5] showed that the effects of light increases from long-waved red to short-waved blue.[9] Jores found that the water-soluble hormone of frogs and mice increased in their pituitaries in light rather than in darkness, but in an inactive form. In guinea pigs the vasopressor and uterine-stimulating factors of the pituitary are doubled or trebled by darkness, or by covering the animal's eyes. So, while melanophore hormone in its active phase decreases in the dark, the anti-diuretic, blood pressure-raising and uterine-stimulating hormones of the posterior lobe increase. Jores was of the opinion that the vasopressor hormone is the inactive phase of the melanophore hormone and that its large amount at night causes the greater number of births at night than in the daytime.

Certain clinical problems may find an explanation in the varying hormonal content of the pituitary during daylight and darkness. Attention is called to the fact that there is a nervous connection between the posterior pituitary and hypothalamus. The functions of the latter have been shown to be many and varied. Some of these are temperature regulation, variations in emotions, an influence on blood sugar, water and chloride regulation, nervous influence on gastro-intestinal and cardiac regulation, fat metabolism, sleep and several others. The hypophyseal-hypothalamic system plus the optic tract have close physiological and anatomical connections. As has been stated, these systems therefore, are influenced by light and darkness.

Of interest in this connection is the cyclic variation during the twenty-four hour period of temperature, concentration and amount of urine, besides other conditions such as the blood sugar content. Jores[9] made a study of the pituitary and its varying hormonal content as influenced by light and darkness and applied the facts to cyclic variation of the twenty-four hour metabolism and functions. He delves into the plant world to find substantiation of his work. For example, he calls attention to the opening and closing of certain flowers such as the "four o'clock." The opening and closing of the petals was so precise that one could set his watch by this mechanism. Many plants open and close during the twenty-four hour period so that one can say, like humans, that they have a sleeping period.

The most impressive phenomenon of the cyclic twenty-four hour period is, perhaps, sleep. Customarily, this is done at night. During sleep there is a shifting of the blood toward the acid side and an increased excretion of phosphate in the urine. The rhythm of temperature stands in direct relation with the utilization of oxygen as well as the excretion of carbon dioxide. The maximum exchange for these substances is in the late afternoon, the minimum in the early morning hours. The maximum and minimum variations produce rhythmic changes in the pulse and blood pressure. Also the cell content of the blood, particularly the leukocytes, vary during the day. Forsgren and his pupils found important changes in the liver during different times of the twenty-four hour period.[9] They found two distinct cycles—during the first period glycogen is stored, and in the second, bile is produced. The first cycle began at 2 o'clock and the second at "14 o'clock." Likewise the concentration of urine and its activity varied. In the early morning hours (2 to 4 o'clock), the minimum of nitrogen is excreted and in the forenoon from 10 to 12 o'clock, the maximum is excreted. This is supposedly due to a rhythmic change in the vegetative nervous system as well as to the activity of the endocrine glands. A close relationship exists between the adrenal glands and the sympathetic system and between the pituitary and parsympathetic system.

The causes of the cyclic variations in the bodily function are many, such as exercise, activity, eating, rest and sleep. These are unquestionably important factors that influence the daily rhythm but are not the only ones. This has been shown in individuals who reversed the customary way of living, that is, slept during the day and were awake at night. Neither the temperature cycle nor the urine excretion was disturbed by this change. The individuals undergoing the experiment had been living under these conditions for eight years.

It is believed that this twenty-four-hour cyclic periodicity is the cause and not the result of mankind's schedule of life.

Stoppel undertook an expedition to the land of the midnight sun in order to see if the movements of flower petals would open and close as in the temperate zone.[9] When the flowers were placed in the cellar they no longer went through the cycle but when a sheet which had been exposed to the sun was taken into the cellar, the cycle was resumed.

Bissonnette[1] said that there is increasing evidence of the induction of physiologic and cytologic changes in the pituitary gland by nervous excitation and some evidence for such changes in response to modified exposures to light. He found at the crest of sexual activity vacuoles in both the basophils and the eosinophils of the anterior lobe like those in "castration" cells. The results suggested that one of these types of cell secretes a hormone controlling the interstitial cells of the testis and the other a hormone stimulating the germ cells. Others, however, using different animals, have found a seasonal cycle of the anterior lobe.

In connection with the latter statement it is interesting to note the hibernation of animals.

Cushing and Goetsch[3] advanced the hypothesis of the seasonal nature of hibernation due to polyglandular inactivity as the etiologic factor. Recently Foster, Foster, and Meyer[5] in reviewing the influence of the endocrine glands on hibernation, concluded that their findings suggested inactivity of the pituitary gland as the primary factor responsible for the phenomena of hibernation.

Zondek and Bier[12] said that animals can be brought out of their hibernating state by placing them in artificial light and heat. Pregnancy is at a standstill during the hibernating period of the bat but proceeds normally when the animal is placed in artificial light and heat.

It is well established that during the hibernating state of animals the chromophobes of the pituitary are hyperplastic. This state is comparable to the colloid, or resting state of the thyroid gland associated with myxedema or hypothyroidism. It is my opinion that the ordinary type of Fröhlich's syndrome is due to hyperplasia of the chromophobes. In animals when normal hibernation ends because of cosmic or other influences, the hyperplasia of the chromophobes is replaced by hyperplasia of the chromophils, and the animal goes into estrus, with consequent metabolic and cellular activity.

The cyclic variation of symptoms of ulcer suggests that the season of the year may influence the hypothalamic-hypophysial system. This would tend to bear out Cushing's neurogenic hypothesis[2] of peptic ulcer as due to a disturbance in the interbrain area, since the rhythmic variation of endocrine function is not unlikely. His clinical experience with tumors of the midbrain area associated with peptic ulcer is suggestive. Furthermore, the beneficial effect of sunshine in certain diseases makes it not unlikely that the mechanism operates via the hypothalamic-hypophysial system. The influence of the pituitary gland on the skeletal system suggests that activation of this gland by sunshine may be the answer as to why this form of therapy benefits rickets and other allied disorders.

It is not within our province to discuss the close association between sunshine, vitamins and the hormones, but a physiologic relation, especially in conjunction with ocular pigmentary disturbances, such as xerophthalmia and retinitis pigmentosa is obvious.

The rhythmic cycle of pituitary cytologic changes has also been found by Zahl, who noted that the acidophils in frogs were in greatest number and with the most abundant granules and fuchsinophil droplets in spring and early summer.[1] They were less numerous in late summer and increased gradually in autumn and winter, to discharge again in spring.

Florentin and Stutinsky[4] found that when frogs were kept in a dark room the anterior lobe of the pituitary gland soon lost its chromophobes and that only a few basophils and many acidophils remained. The pituitary gland was in a state of arrested function and showed the effects of lack of photopituitary reflexes.

Bissonnette, in his conclusions, stated:

> All of the above studies show effects of light and darkness, and even of specific wave-lengths of light on some animals, mediated by the eyes, optic nerves, and pituitary and accompanied by cytological and physiological changes in the gland, and in the pituitary activity. These types of changes vary in different species, often in correlation with changes induced by other factors in the environment.
>
> We require much further study of these photopituitary reactions in many more animals before we can arrive at any very broad generalizations. But we already know that in many cases the daily period of light, its intensity, and its wave-length control and modify pituitary activity.

It is most reasonable to suppose, therefore, that girls in the tropics would menstruate and mature earlier than those in temperate zones.

In ornithology, studies showing the variation in the intensity of light, wave-length of light, and alteration of the daily periods of light influences

the migration of birds by cellular changes in the pituitary.*

Changes in the relative activity and size of the sex-glands and secondary sexual organs are assumed to be evidence of changes in the anterior pituitary.

Juncos (American finch or snow-bird), crows and canaries were studied by Prof. Rowan of Edmonton, Canada.[1] He was interested in the relation of migration to change in length of daily periods of exposure to light. He was able to control and modify the time of the year at which the birds become sexually active by increasing or decreasing their daily periods of exposure to light by adding electric light after nightfall or reducing it. He obtained sexual activity in these birds at any desired time of the year, even in spite of temperatures as low as minus 50°F.

Bissonnette experimented on starlings, field mice and ferrets. In starlings, sexual activity was induced in Autumn, Winter, or Spring by increasing the daily periods of exposure to light, and regression by decreasing it. Rate of acceleration of sexual activity varied with luminous intensity up to an optimum; more intense light gave a greater effect than less intense. But light could be too intense for greatest acceleration. Wave-length of light was also a factor; long-waved red light was most stimulating, perhaps that is where the red light originated, to indicate a sporting house. Shorter-waved green and blue were not activating. If anything, they appeared to be slightly inhibitory as judged by size and condition of the sex glands in comparison with those of animals without added lighting. Improper food was a limiting factor, since lack of vitamins, proteins or fats prevented even very stimulating red light from inducing more than very slight activation in a considerable time. Even light after a time will lose its effectiveness and the animals become refractory to the stimulus of light and regression sets in just as it does in many animals become refractory during long continued injections of gonadotropic hormones from the anterior pituitary.

All sexual cycles in animals cease following hypophysectomy and increased lighting fails to induce any sexually stimulating effect. The eyes are the normal receptors for pituitary stimulation by light but in the absence of eyes in the duck and frog, at least the recently cut optic nerve endings may be directly stimulated by light and lead to increased pituitary stimulation of sexual or coloration activity; or in the duck, the pituitary itself may be stimulated directly by light directed upon it and stimulate the sex organs to activity.

In the ferret, severance of the optic nerves frees the animal from the photic stimulus to sexual activity, and the animals have an inherent sexual cycle, independent of seasonal light changes.

In some animals the seasonal shedding of hair is also related to seasonal light cycle rather than to temperature. Hypophysectomy leads to loss of this marked seasonal moult and severance of the optic nerves dissociated it from the seasonal light cycle in ferrets along with the sexual cycle. Many animals are stimulated to sexual activity by increasing illumination, some by its decrease, and some are not sexually photo-periodic at all or very slightly so.

Dr. Cook, apparently the same one who came into disrepute, reported in 1894, on the basis of the Peary Expedition, that the Northern Eskimo women do not menstruate or have sexual cycles in the long winter night. The men of the expedition also undergo a certain amount of lassitude and lack of sexual interest, which is peculiar when you know the reputation of sailors. Of course, this report coming from Dr. Cook may not be reliable, although at the other extreme of the earth, in Patagonia, in Southern South America, Havelock Ellis stated that the women of this country show a cessation of sexual activity in the winter. This paragraph is in substance a quotation of Bissonnette.

There are of course many other applications of light on human activity and mental moods, since the pituitary and the hypothalamus have a direct nervous connection. It may be cited for instance that the irritability and moodiness of women at the time of menstruation is understood by the pituitary-hypothalamic changes. Then, too, the involutional melancholia may have its explanation in the changes which this area undergoes at the menopause. Emotional upsets, worry and other nervous factors no doubt affect this area and by this the sexual cycle.

If one grants that the pituitary gland is related to the formation of pigment, then the activity of the melanophore hormone of the Negro would, pari passu, be greater than that of the Caucasian.

*The thoughts expressed here in regard to birds and animals are those of Bissonnette, upon whose work I have drawn freely.

The Negro, at one time, probably possessed a very active pituitary gland. Even today this seems to be true. Freeman,[6] for instance, studied the relation of the weight of the whole pituitary gland of the male to weight, stature and race. He said that the weight of the pituitary gland is better correlated with body-weight than with stature and that the pituitary gland of the Negro is heavier than that of the Caucasian if the weights of the pituitary glands of persons of the same sex are compared.

For some time, I have stressed that the pituitary gland has a selective action on mesodermal tissues. If this is true, then the heavier pituitary gland of the Negro would by analogy produce certain peculiarities in the mesoderm of the Negro that would make this layer and its derivatives unique when compared with those in the white race. Details of this have been given elsewhere.

Originally, the Negro possessed a well-developed mesoderm, and the ectodermal structures, such as the nervous system, were in comparison less developed.

The mesoderm was necessary for the development of muscular strength, the skeletal system, immunity and procreative powers. The Negro race is phylogenetically a closer approach to primitive man than the white race. Of particular importance is the fact that a white person with acromegaly takes on the physical characteristics of the Negro. The white man reverts to the primitive type. Keith said:[10]

"I came to the conclusion then, which prolonged observation has gone to confirm, that the cranial and facial features of primitive man and those of acromegalic men and women are of the same nature, only in primitive man they were produced by a normal or physiological action, whereas in the acromegalic they are the result of an abnormal or pathological action."

Furthermore, he added:

"There still lurks in the body of modern man the machinery which fashioned the ample features of Rhodesian man and which can be awakened under conditions of disease. It is the same machinery which determines the more exaggerated degree of bestial strength seen in the face of the gorilla."

Peculiarly enough, but readily understandable, is the fact that the hyperpituitary states, acromegaly and the pituitary basophilism of Cushing, are found almost exclusively in the brunette. Dark-complexioned females with hirsutism are more apt to have menstrual disturbances than the blond, and the latter more apt to suffer from sunburn.

As previously stated, the mesodermal layer of the Negro has certain peculiarities as compared to the white person. It will be noted that when disease attacks the Negro, it most frequently does so in the mesoderm, whereas the ectoderm is relatively immune.

We cannot go into any detail or statistical study which proves this, but even a cursory examination will show that the incidence of disease of mesodermal tissues is usually high for the Negro.

It is a generally accepted fact that the Negro has a tendency to connective tissue overgrowth, illustrated by the frequency of keloids, neurofibromas and fibroid tumors of the uterus. Disturbances in the bones of the Negro are unusually common, such as rickets, osteomalacia, gummas and yaws.

The hematopoietic system shows singular characteristics. While pernicious anemia, the leukemias and thrombocytopenic purpura are all rare diseases in the Negro, sickle cell anemia is a disease limited almost exclusively to this race. Melanosarcoma is also a rare disease in the Negro.

The foregoing diseases are but a few examples which show the differences in the mesoderm of the Negro and the white races.

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MSMS

Children need praise and encouragement. Material praise in the form of something the child's heart craves is the sort that reaches them soonest and stays with them longest, for they are children and still love childish things.—Angelo Patri.

Chronic Non-Specific Prostatitis and Gastro-intestinal Complaints

By Joseph A. Winter, M.D.
St. Joseph, Michigan

EVERY GENERAL practitioner frequently sees patients who present vague gastro-intestinal complaints. These patients give a history of having had "stomach trouble" for years; they complain of attacks of abdominal pain, gassiness, flatulence, inability to eat fried and greasy foods. They are frequently inveterate takers of soda and proprietary antacids. They usually tell of having "doctored" for these complaints with very little success. Some of them have had x-rays of the gastro-intestinal tract; almost invariably these roentgenograms show nothing wrong with the stomach.

Of all the diagnostic procedures to which these patients have been subjected, the complete examination of the prostate gland is the one most frequently overlooked. An occasional patient will tell of having had one rectal examination, but this is exceptional.

The value, in fact the necessity, of examining the prostate gland has been stressed again and again in all medical publications. In spite of this, it seems that the region of the prostate remains *terra incognita* to an unfortunately large percentage of general practitioners. Too many of us are apt to forget that there is an easily accessible orifice near the lower end of the vertebral column, that a finger can be inserted into this orifice and that pertinent and valuable information can be gained by so doing. Although it has been said many times before, it should be said again that the investigation of the prostate gland is as important a part of the examination of the male patient as the investigation of the mouth.

The examination of the prostate consists of two steps. The first is the gentle insertion of the lubricated gloved finger into the rectum and the gentle palpation of the gland, observing the size, shape, consistency and degree of tenderness. After this has been accomplished, gentle pressure on the gland will result in expulsion of the prostatic secretion, which should be examined under the microscope, using the dry, high-power objective.

A normal prostatic smear shows less than 10 pus cells per high-power field, plus globules of lecithin; at least three such normal smears should be obtained at weekly intervals before it can be said that prostatitis does not exist.

Incidence

Chronic non-specific prostatitis is of almost unbelievable frequency. A study of inductees made at Fort Sill showed that approximately 20 per cent of a group of young American men had demonstrable prostatic inflammation.[2] Other authors estimate that an even higher percentage of prostatitis exists; Hinman[4] says that 35 per cent of all males have infected prostates, while Nicholson[6] says that, of men past thirty, 35 per cent have prostatitis. Routine prostatic examination on all my male patients has convinced me that these figures are definitely not exaggerated.

Symptomatology

The symptoms of chronic prostatitis, as discussed in medical literature, are usually classified in two groups, the urinary and the sexual disturbances. Among the urinary symptoms, according to Kretschmer[5], are urethral discharge, frequency, burning, nocturia, urgency, hesitation, stinging, pyuria, dribbling, hematuria, straining and prickling. Of these, personal observation has led me to conclude that the symptom of dribbling, that is, wetting one's underclothing shortly after apparently completing the act of urination, is pathognomonic of prostatitis.

Sexual disturbances include insecure, painful or absent erections; premature, delayed or sensationless ejaculations and loss of libido.[9]

A search of the literature has shown that few authors have stressed the relationship between prostatitis and gastro-intestinal complaints. Nicholson[6] mentions that, as a focus of infection, the prostate can produce functional complaints of the gastro-intestinal tract. Henline[3] says that gastro-intestinal manifestations may appear and "dyspepsia" and flatulence may be prominent. Wesson[9] states that abdominal symptoms are not uncommon, and that gastroenterologists are sometimes consulted because of a complaint of obstruction or tumor in the lower bowl, due to the presence of an enlarged prostate. Adams[1] mentions that appendices are removed in the course

of a genital infection such as prostatitis. Turner[7] says that functional gastric disturbances can occur as a result of prostatitis.

The symptoms referable to the digestive tract, and caused by prostatitis, include the following:

1. A sensation of fullness in the epigastrium.
2. Gaseous distension and flatulence.
3. Inability to eat, without discomfort, such foods as fat foods, greasy foods, the gas-forming vegetables. Occasionally, the patient complains of inability to digest starches.
4. Pain, of varying degrees of severity, around the umbilicus or following the line of the belt around the abdomen. This pain seldom has any definite relationship to food intake. One common complaint is that the pain comes on an hour or so after breakfast, then persists throughout the day, without being relieved by eating. Again, one hears that the pain is relieved by food and antacids.
5. The appetite may be almost non-existent or it may be good, in spite of the complaints of abdominal discomfort.

It can be seen that all these complaints are vague and do not quite fit into the category of gall-bladder disease or of peptic ulcer. It is always a temptation to suggest that the patient have a roentgenographic study of the gastro-intestinal tract, just to be on the safe side. But this added expense to the patient can be obviated if further questioning elicits such complaints as dysuria, nocturia, dribbling, backache and loss of potency. A rectal examination which reveals a swollen, tender prostate and the appearance of pus cells, singly or in clumps, on the microscopic slide, clinch the diagnosis.

Case Histories

Case 1.—J. H., aged thirty-nine, married, laborer, had had a "bad stomach" for several years. He complained of gassiness and said his food soured on his stomach. He had pain in epigastrium and lower abdomen; occasionally had precordial pain and a smothery sensation on lying down. He was constipated; took milk of magnesia about every other day. He had had x-rays of the stomach and intestines within the last two months; these showed no evidence of any disease process. Further questioning revealed the complaints of backache and nocturia twice nightly. Rectal examination showed an enlarged, tender prostate; smear 4 plus pus.

He was given capsules of Ext. Belladonna, Phenobarbital and Kaolin to relieve the symptom of gassiness, and was started on a course of prostatic massages. After three weeks, during which time he was massaged twice a week, he was totally relieved of his gastro-intestinal symptoms, and was able to discontinue all medications without return of his complaints. He made the observation that he felt better than he had for years and that he was convinced that, for the first time, the actual cause of all his difficulties was being treated.

Case 2.—A. D., aged thirty-five, married, factory worker, complained of vague gnawing pains in upper abdomen, coming on about two hours after breakfast. Pain was relieved by eating, partially relieved by antacids. Appetite was good. He was distressed by such foods as cabbage and onions. He had a tendency toward impotency. The prostate gland was swollen and tender. Smear showed occasional pus cell and absence of lecithin globules. A smear taken four days later showed 2 plus pus, while a smear taken three days after the second showed 4 plus pus, cells being found singly and in clumps. He is still under treatment, but his gastro-intestinal complaints have entirely disappeared.

Case 3.—O. P., aged forty-eight, married, machinist, had had "stomach trouble off and on for the last twenty years." He complained of pain in the umbilical region, the pain coming and going and especially worse at night. Pain was relieved by taking food. He was frequently nauseated after meals, especially after breakfast. Highly seasoned foods caused distress. X-rays taken three years ago showed a normal stomach and duodenum. Prescribed antacid medications gave only temporary relief. The genito-urinary history showed nocturia of once nightly, increased urinary frequency in cold weather and impotentia eregendi. The prostate was enlarged to almost twice normal size and extremely tender. It was impossible to obtain any prostatic secretion at this time and also with the next massage. The third massage showed 2 plus pus and an absence of lecithin globules. Even at that time his gastro-intestinal complaints were decidely relieved.

Comment

These three cases show all the points which are desired to be made. The patients have complaints strongly suggestive of peptic ulcer or gall-bladder disease, but yet these complaints are not quite typical. These patients had all had previous medical attention for their abdominal distress, getting only temporary relief from the usual medical and dietary regime. None of them had ever had an examination of the prostate. They all obtained noticeable relief after three or four massages and continued to improve with further treatment. It was necessary to repeat examinations before obtaining microscopic proof of infection.

These cases are presented because they are illustrative of the relationship between prostatitis

and gastric dysfunction, not because they are unusual. Within the last five years at least twenty-five other similar cases have been seen and treated with satisfactory results in relieving the gastro-intestinal difficulties.

No discussion has been made of the technique of prostatic massage; that has been so completely described in the texts and in the literature that further exposition would be redundant. Nor has there been any attempt to discuss the etiology of prostatitis; it is apparently agreed that focal infection elsewhere in the body is most apt to be the cause.

Some mention should be made of the possible endocrinologic effect of prostatic massage. The prostate is said to have no demonstrable internal secretion[8], yet the effects of prostatic massage are so similar to those obtained from the administration of testosterone, especially as regards such complaints as nervousness, irritability, loss of libido and sluggish cerebration, that it seems worth while to suggest that this subject is deserving of further investigation.

Summary

1. Various vague gastro-intestinal complaints, suggestive but not typical of peptic ulcer and cholecystitis, are apparently caused by chronic non-specific prostatitis.

2. The value of prostatic examination and treatment of prostatitis is again called to the attention of the profession.

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DOCTORS NEEDED!

Report from Procurement and Assignment Service

AREAS NEEDING MORE PHYSICIANS

City	Pop.	County	City	Pop.	County
Charlevoix	2299	Charlevoix	Gladwin	1600	Gladwin
Clare	1844	Clare	White Cloud	811	Newaygo
Clio	1711	Genesee	Shelby	1367	Oceana
Sunfield	348	Eaton	Mio	600	Oscoda
Beaverton	528	Gladwin	Decatur	1599	Van Buren

Michigan State Reformatory, Ionia. A physician is needed here. Write to David P. Phillips, M.D., Acting Warden, Michigan State Reformatory, Ionia, Michigan.

Lapeer State Home & Training School, Lapeer. Male and female physicians are needed. Excellent opportunity for training and experience in research in General Medicine, Pediatrics, Orthopedics, Surgery, Endocrinology, Neurology, and Psychiatry. Located 60 miles due north of Detroit. Write to R. E. Cooper, Med. Supt.

AREAS WITH NO PHYSICIANS

City	Pop.	County	City	Pop.	County
Lincoln	295	Alcona	Middleton	450	Gratiot
Central Lake	659	Antrim	Bannister	262	Gratiot
Ellsworth	347	Antrim	Cambria	200	Hillsdale
Standish	981	Arenac	Montgomery	313	Hillsdale
Au Gres	317	Arenac	Waldron	424	Hillsdale
Baraga	1110	Baraga	North Adams	496	Hillsdale
Freeport	405	Barry	Hubbell	1100	Houghton
Auburn	600	Bay	Sidaw	300	Houghton
Benzonia	340	Benzie	Beacon Hill	200	Houghton
Elberta	617	Benzie	Okemus	300	Ingham
Thompsonville	324	Benzie	Dansville	351	Ingham
Stevensville	382	Berrien	Webbersville	508	Ingham
Bedford	300	Calhoun	Clarksville	309	Ingham
Tekonsha	636	Calhoun	Alpha	497	Iron
Jones	200	Cass	Rosebush	400	Isabella
Indian River	300	Cheboygan	Weidman	350	Isabella
Topinabee	121	Cheboygan	Kalkaska	1132	Kalkaska
Trout Lake	260	Chippewa	Augusta	785	Kalamazoo
Barbeau	100	Chippewa	Parchment	934	Kalamazoo
Rapid River	350	Delta	Ada	450	Kent
Sagola	800	Dickinson	Luther	343	Lake
Levering	300	Emmet	Cedar	265	Leelanau
Alanson	330	Emmet	Northport	606	Leelanau
Montrose	675	Genesee	Clayton	395	Lenawee
Marenisco	400	Gogebic	Cedarville	400	Mackinac
Anvil Location	500	Gogebic	Onekama	340	Manistee
Watersmeet	600	Gogebic	Gwinn	1300	Marquette

(Continued on Page 242)

Home Service for Veterans

The eyes of this Nation have been focused on the Veterans Administration awaiting an answer to the question of how the disabled soldier is to be cared for. Present-day Veterans hospitals are not adequate in size and equipment to care for the vast number of returned men who need treatment, and it will take many months, even years, to provide necessary bed space to supply the demand.

Fortunately an answer to the situation has been furnished in Michigan by a mutual and harmonious understanding between the Veterans Administration and the doctors of medicine. It is a recognition that this health problem of National scope can best be administered on a local level, and at the same time ease the load on overcrowded government hospitals. The Veteran can have the doctor of his own choice, and he can remain home.

The State-wide plan is the first of its kind, and merits the wholehearted support of every physician in the State. If successful, the use of the family Doctor by the Veterans Administration, will be sure to spread over the whole country. To succeed, every disabled veteran must receive, and is entitled to receive the very best service the medical profession is capable of rendering, thus demonstrating in a practical way that the private practice of medicine is the best way for all concerned.

President, Michigan State Medical Society

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President's

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Editorial

MICHIGAN MEDICAL SERVICE AND THE VETERAN

MICHIGAN MEDICAL SERVICE has signed a contract with the Veterans Administration for the care of veterans with service-connected disabilities by their home doctors. There has been much dissatisfaction with the care rendered the veterans in the past. The veteran had to make long trips to the hospitals, and then arrangements had to be made with the home doctor and the bureau for the care. The result was sadly disappointing, the publicity was widespread and unfriendly to the Veterans Administration. So far as Michigan is concerned that is all in the past now. The same condition can be true in other states. Michigan again has pointed the way.

The suggestion of caring for the veteran through his family doctor and our Michigan Medical Service was made many months ago. Plans were developed, studies of the problem made, contacts with the American Legion, and the Bureau at Dearborn, and then an attempt to get the proposal presented to the Administration in Washington. This first attempt was summarily rejected. We did not despair, and continued to perfect plans. Last October Major General Paul R. Hawley, Chief of the Medical Service of the Veterans Administration, made a speech in which he related their problems and asked for a solution, suggesting some kind of a working arrangement with the organized medical profession. This speech led to a renewed contact with the Veterans Administration, a conference with Major General Hawley, and a trip to Washington by several of our officers where the plan was approved. Details have been worked out, and a contract was signed December 27, 1945. General Omar N. Bradley, the new head of the Veterans Administration, made the announcement to the press and wide publicity was obtained.

By deciding to use existing agencies, General Bradley and Major General Hawley have introduced a practical plan for veterans' medical care which can be in full operation in weeks instead of years. They have developed a pattern which, if pursued nationally, will save much time and expense otherwise required for travel of veterans to veterans' institutions, and they have further advanced General Bradley's announced policy of decentralization.

Briefly, Michigan Medical Service through its registered participating doctors will give the veteran home and office care for service-connected disabilities. For male veterans that includes all disabilities that are accepted by the Veterans Administration as having been due to military service. For the female veteran that includes all services other than normal deliveries. The law now provides for such services, and also that veterans with non-service connected disabilities may receive care if they sign a statement that they are unable to pay the regular fees, and there is a hospital bed available. There are no Veterans Administration beds for women.

This contract went into effect January 15, 1946. Information and instructions have been sent to the Michigan doctors, with a card to sign indicating the willingness of the doctor to render this service at the fee scheduled. This is the Minimum Uniform Fee Schedule For Governmental Agencies adopted by the Michigan State Medical Society House of Delegates in September, 1945. It is necessary that this card be signed and returned to the Executive Office at once in order to place the doctor's name on the registered list. These names will automatically be placed on the "Fee Designated" list. Only Doctors of Medicine on this list can be paid for services to veterans.

When a veteran thinks he has a disability needing attention and traceable to war service, he writes the Veterans Administration in Dearborn, Michigan, asking for registration. If it is an emergency, he or his representative, who may be his doctor, may call the Veterans Administration by telephone collect, and get an immediate authorization. Michigan Medical Service is promptly notified and the veteran given a card which is his authority for care from his home doctor. A single report is made on a very much shortened form, and sent to Michigan Medical Service, which will pay the doctor and be reimbursed by the Veterans Administration.

Much commendation is due the officers and committees of Michigan Medical Service for making this care available to the veteran in his home

town, and by his own family physician. A service has also been rendered to the doctor, as it restores to his care literally thousands of his patients who otherwise would have been regimented into state medicine. A precedent has now been established whereby government recognizes the voluntary nonprofit plans for the rendition of services to its wards.

A MEDICALLY SPONSORED HEALTH LEGISLATION PROGRAM

A SET OF PRINCIPLES for the provision of medical care by health legislation beneficial to the people was adopted at Chicago, December 2, 1945. The sponsoring body was two hundred eight executive officers—Presidents, Presidents-elect, Secretaries, Editors, and Executive Secretaries, representing forty-two State Medical Societies. This resolution was presented to the American Medical Association House of Delegates, and orders were issued by that body to study for six months. *THIS WILL BE TOO LATE!* This set of principles in in the form of a resolution was published in the December number of THE JOURNAL. They were repeated in the January number. We are repeating them again in this issue.

Why the repetition? We believe this is one of the most momentous actions taken by an organized and thinking medical profession. We believe this action should have been taken long ago, but think if it is followed up promptly and vigorously it may not be too late. President Truman gave us a speech on November 19, 1945, which pointed out the way those in power in Washington are now thinking. He had hinted at the same thing on September 6, but detailed his plan on November 19. This same day Wagner, Murray and Dingell reintroduced their socialized medicine bills, changed in some minor details, but accomplishing the same purpose as their predecessors. January 3, 1946, President Truman again appealed to the people in behalf of his legislative plans, and mentioned health legislation as one of the "musts."

As indicating the extent to which those who would control medicine and the nation's health, read General Parran's release to "All officers of the Public Health Service" on page 178, written December 10, but released the day after the President's January 3 appeal. One of the Washington Business Letters of this same week stated that part at least of this health legislation will be enacted this year.

We are not scared, but any man with common sense would study the trends in his own business, and make an earnest effort to have some influence on the determination of those trends. Organized medicine has not yet been consulted in the development of social plans involving the whole future of the health of the nation. We must make our opportunity. We must assert our attitude. We must suggest something that can work.

We have done that.

The executive officers of forty-two state medical societies have pointed the way.

We shall continue to present this material as long as there is any hope of making it effective.

There is more of this story to tell.

While the American Medical Association reposes and studies (sleeps is a better word), the proposers of the resolution must be activated by the forty-eight State Medical Societies, as indicated by the final paragraph of the resolution—now, not six months from now.

The Conference of Presidents and other officers of State Medical Societies started this offensive, so while Rome sleeps, the forty-eight fiddlers must quicken their resolution into kinetic action before Nero (Government control) burns up the city.

Michigan is one of the forty-eight. It will do its share of the job, and more. Will the other forty-seven states do as much to save a great profession, and themselves?

GI BILL OF RIGHTS

THE GI BILL of Rights has been referred to many times with commendation for the benefits it gives the returned veteran. No one has begrudged the veteran whatever benefits he may secure from this bill, and in repayment for the sacrifices and services to the country in the hour of war. Recently the benefits have been extended. It has been provided that doctors taking short courses may have the tuition paid even though the course does not extend through the major part of a school year. Allowances have been increased for the monthly living expenses to $90.00 a month for a man with dependents. This still is not adequate considering the housing shortage and increased living expenses.

But now a new difficulty has arisen, and a ridiculous one. It has been interpreted that a returned officer may not take advantage of this schooling while he is on terminal leave. (Terminal leave is

that time the officer is given in lieu of leaves he might have taken but could not because of his war service. It may accumulate up to 120 days, and is an extension of salary after he is separated from active service.) While on this "Leave" and doing nothing but resting, he will not be allowed to start his rehabilitation schooling at government expense. This is a useless waste of valuable time. The doctor wishes to get back home and to work, and his former patients are clamoring for him. He could start his postgraduate courses, and in many cases finish them during this time off, but if he wishes to benefit by the GI Bill of Rights he must wait until his terminal leave is finished. There will be weeks or months of valuable time wasted, and it could be so easily changed. A mere directive. Medical men are not the only ones involved. Soldiers who wish to finish their college courses are finding the same difficulty.

The excuse given for this interpretation is that the veteran is still being paid his salary by the government, and to make the terminal leave and the school period overlap would be to give double benefits. This is not true. The veteran is entitled to the school benefits, and only has to wait to get them. A veteran at his request could be assigned to the school during his terminal leave, and then be placed on allowances when the terminal leave time is passed. This would save time for the student and be an actual saving of money to the government.

AMERICAN FREEDOM THREATENED

THE rising tide of threats against the freedom of American principles is spearheaded by proposals for governmental health insurance.

Despite all assurances to the contrary, it is clear that this is pure unadulterated "socialized medicine," which is always the entering wedge to the general socialization of a country. Surely no one can believe that governmental intervention in private, voluntary activity will stop the socialization of medicine and hospitals. As national socialization in Europe became more widespread with each new contact, so will it in America—if it is not stopped *now*.

It seems especially inconceivable that government should be proposing *compulsory* health insurance when the doctors and the hospitals of the nation already have established their own non-profit *voluntary* organizations to serve the same purpose. These non-profit programs are developing at an unprecedented rate and are performing a splendid service for the benefit of the people. To illustrate their effectiveness, the Michigan plan —Michigan Hospital Service—already protects a quarter of the entire population of this State against hospital bills, and its medical counterpart —Michigan Medical Service—now protects 868,000 men, women and children of Michigan—one in every six persons in this State.

Most unfortunately, the intimate relationship between the doctors, the hospitals, and their own prepayment plan is not understood by a majority of the people. They do not *know* how strongly the hospitals and the medical profession have moved to meet this problem or how rapidly the voluntary programs are being perfected. Until they do know, there will continue to be popular pressure for compulsory government health insurance.

It is the individual responsibility of every doctor of medicine in this State to bring the *facts* to the people—that a plan of medical and hospital care exists in Michigan which is *better* than any experimental plan proposed by politicians in Washington.

The doctor's position enables him to do much to tell the people that he and the other practitioners of Michigan, together with the hospitals, are meeting this problem in the American way—the way the people want the problem to be met.

Public relations begin at home, Doctor!

ON THE RUN . . . .

"Drug fever" must not be ignored since it is a definite danger signal indicating that the patient has been sensitized to the drug being used.

• • •

In gas gangrene, when adequate excision of affected tissue is impossible, local injection of antitoxin may inhibit cytolytic action.

• • •

The possibility of gastric cancer in patients with pernicious anemia must be kept constantly in mind.

• • •

Local treatment of impetigo contagiosa with sulfathiazole carries a risk of sensitization of 2½ per cent of the cases.

• • •

As new specific agents are developed and come into use, it must always be remembered that the doctor has not finished with the case simply by writing a prescription for any of these agents.

Selected by W. S. Reveno

EFFECTIVE in combating cases of unusual vitamin deficiency, the seven vitamins contained in VI-TEENS vitamin tablets each performs a specific task. But it is the SUPER POTENCY of VI-TEENS that supplies the additional margin of safety beyond minimum adult needs. Two Super Potency Vi-teens Tablets daily supply the following amounts:

Vitamin B_1 (Thiamin HCL) (2666 U.S.P. Units)	8 Milligrams
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Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

MICHIGAN'S HEALTH IN 1945

The general death rate is expected to drop slightly below last year's rate of 10.05 per 1000 population to about the five-year average of 9.9. The infant death rate, most delicate index of the health status of any community, will be the lowest in Michigan's history. There was no over-all increase in the communicable diseases with the exception of diphtheria.

The ten leading causes of death continued in the same order as in 1944. As usual, heart disease led all other causes of death in Michigan with cancer second. During the first ten months there were 14,201 deaths due to heart disease against 14,030 for the same period last year. Cancer killed 5,902 persons during the ten-month period compared to 5,791 last year. Apoplexy was in the third place for the ten-month period with 4,278 deaths, followed by accident, 2,766; nephritis, 2,168; pneumonia, 1,477; tuberculosis, 1,465; diabetes, 1,245; premature births, 1,121; and hardening of the arteries, 818.

For the first ten months of 1945 deaths of infants under one year of age were at the rate of 36.12 per 1,000 live births, compared to the ten-year average of 42.02. Also at a record low are maternal deaths which were at the rate of 1.5 per 1,000 live births against the ten-year average of 3.01.

Total number of babies born in 1945 will reach 112,000 judging by the figures for the first ten months. This is a slight drop from the previous five-year average.

Cases of most communicable diseases were below average during the year. Diphtheria, an exception, reached its highest point since 1937 with 629 cases reported compared with 418 for 1944. During the first ten months there were thirty-nine diphtheria deaths reported compared with twenty deaths for the corresponding period of 1944. A major epidemic was apparently averted by a wide-scale immunization program. Physicians' requests for the health department's free diphtheria toxoid more than doubled in 1945 over the previous year.

Reported cases of poliomyelitis for 1945 totalled 215, compared to a five-year average of 357. Of these 1945 cases, forty-three were from Detroit. The remaining 172 were largely centered in the southern half of the lower peninsula; no cases were reported from the Northern Peninsula. Of the 215 reported cases, paralysis could be demonstrated in 102. Three cases were undetermined; 110 were cases in which paralysis was not demonstrated at any time.

In reviewing the poliomyelitis incidence for the past twenty years, peaks of high incidence would seem to be spaced four years apart. Michigan's highest poliomyelitis year was 1940, when 1,228 cases were reported.

Cases of Brucellosis (undulant fever) totalled 243 compared with 96 for 1944.

Typhoid fever was at an all-time low with only fifty-seven cases reported against seventy-seven last year. Ten new typhoid carriers were identified.

Incidence of measles was at the lowest point in eight years with 6,124 cases reported. However, toward the end of the year there was a marked increase in cases.

Newly reported cases of syphilis dropped eight per cent during the first 11 months compared to the same period in 1944. This is probably due to the decrease in Selective Service examinations. However, the 14,794 cases reported are still above the five-year average. Reported cases of gonorrhea totalled 11,625, an all-time high.

STAFF MEMBERS RETURN FROM MILITARY SERVICE

Col. Stuart T. Friant, on military leave from the Michigan Department of Health since November, 1940, has returned as Director of the Bureau of Records and Statistics.

Col. J. T. Tripp has returned after three and one-half years' military leave to the Bureau of Laboratories where he is Chief of the Biologic Products Division. Col. Tripp was on loan from the Army Medical Corps to the Chinese government for the purpose of establishing standards for the manufacture of biologic products.

NEW HEALTH DIRECTOR APPOINTED

Russell Pleune, M.D., M.P.H., has been appointed director of the Northern Peninsula Office of the Michigan Department of Health, succeeding W. J. Menke, M.D., who has resigned to enter private practice. Prior to entering military service, Dr. Pleune was director of the Houghton-Keweenaw health department.

GAMMA GLOBULIN FOR MEASLES MODIFICATION

Since 1946 is likely to be a high measles year, physicians may be interested to know that the health department has a supply of gamma globulin for modifying the disease. This product, offered in co-operation with the American Red Cross, was obtained as a byproduct from blood donated by volunteers through the American Red Cross for the armed forces.

NEWS BRIEFS OF 1945

During the year 2,275 patients were treated at the Michigan Rapid Treatment Center in Ann Arbor. Of these 1,249 had primary or secondary syphilis. All patients accepted were unable to pay for private care and were referred by their physician or health officer.

* * *

During the year 2,269,777 doses of biologic products were produced by the Bureau of Laboratories for free distribution. The Laboratories ran 1,236,514 tests for physicians of the state.

(Continued on Page 228)

New

MICHIGAN STATE MEDICAL SOCIETY COMMERCIAL RADIO PROGRAM

Tuesdays at 8:15 p.m.

Over augmented Michigan radio network including WELL Battle Creek, WBCM Bay City, WATT Cadillac, WXYZ Detroit, WDBC Escanaba, WFDF Flint, WLAV Grand Rapids, WJMS Ironwood, WIBM Jackson, WKLA Ludington, WDMJ Marquette, WKBZ Muskegon, WSOO Sault Ste. Marie, WTCM Traverse City.

10-10:15 p.m.
WJIM Lansing

This is your program
Invite Your Patients To Listen In

NEWS BRIEFS OF 1945

(Continued from Page 224)

Postwar plans for water supplies and sewage disposal plants involving more than $150,000,000, were reviewed by the Bureau of Engineering for the State Planning Commission.

* * *

In an effort to conserve the hearing of school children, 25,000 children in 50 schools were given hearing tests. Approximately four out of every 100 children were found to have a hearing loss and to need treatment by an ear specialist.

* * *

Using three x-ray units in fifty-seven counties the state health department x-rayed 108,000 persons in 1945. Although the number of patients in Michigan's sanatoria has remained practically the same for the past two years, there was a decrease in the number of new cases reported in the first 11 months of 1945, a total of 5,014 cases reported against 5,940 for the same period last year.

RED CROSS PLASMA RELIEVES STATE SHORTAGE

New impetus to Michigan's civilian blood plasma program is given by release of surplus dried plasma to the states by the American Red Cross. Shortages of blood plasma have existed in some areas where demands of large hospitals exceeded the area's blood donations. Availability of Red Cross plasma improves this situation. With this additional plasma to supplement supplies, the state health department now plans to expand its program to include production of gamma globulin and serum albumin.

Correspondence

Dec. 12, 1945.

Michigan State Medical Society
Lansing, Michigan

Gentlemen:

I would like to express to you my personal appreciation of the fine quality of leadership that the Michigan State Medical Society has given American medicine, and particularly in view of the fact that this leadership has produced some specific results in the way of the action of the AMA House of Delegates. I know that many men and state organizations share with me this admiration and appreciation of service the Michigan Society has rendered to the medical profession of the United States.

Your state officers, and other interested individual doctors have a truly broad understanding of the problems facing American medicine, and have done something constructive about it. Your men have shown a fine interested devotion to this cause, and have neither spared themselves of effort or energy, or the necessary money to bring the program to successful conclusion. I wish to congratulate all of you.

Sincerely yours,
(Signed) ARTHUR J. OFFERMAN, M.D.
President
Nebraska Surgical Plan
Omaha, Nebraska

---

14 Dec. 1945

Editor, JOURNAL
Michigan State Medical Society

Dear Sirs:

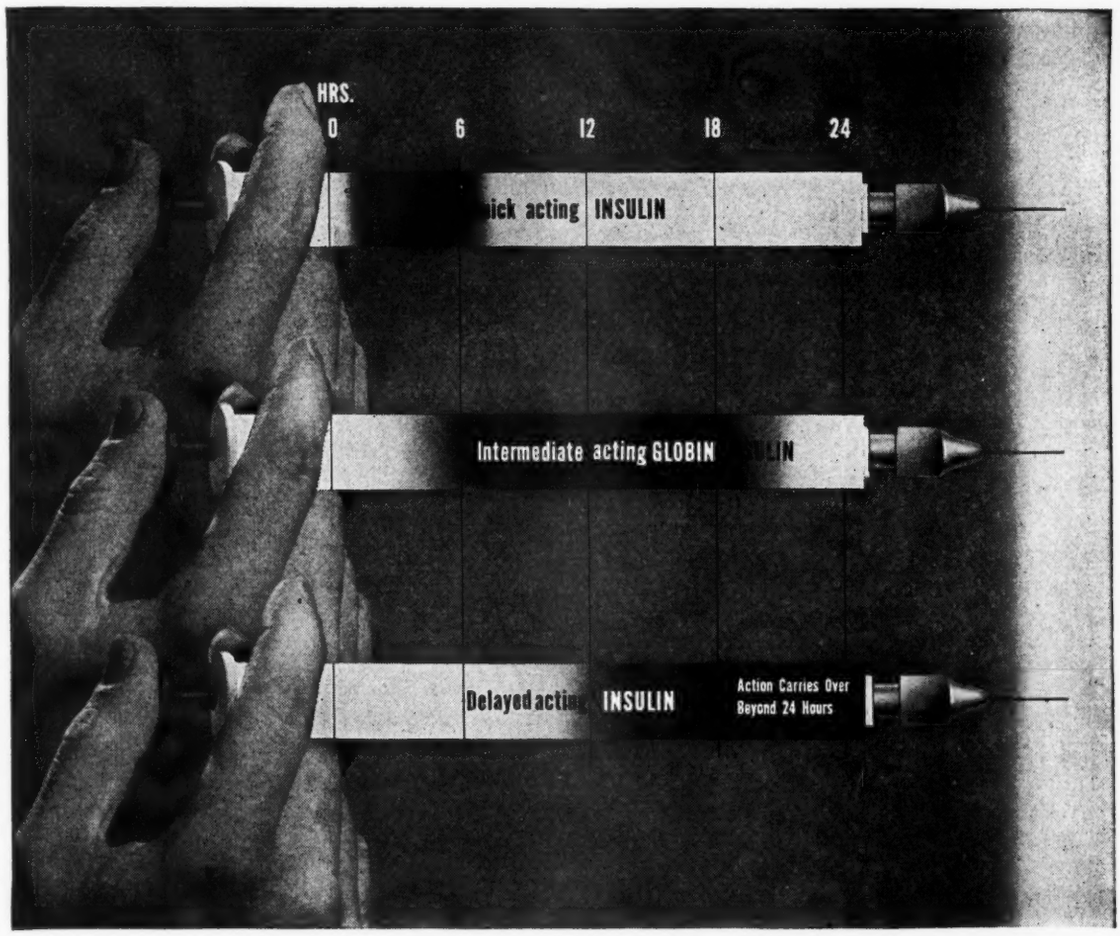
I have only today received my JOURNAL of June, 1945, since it traveled to Europe and back to reach me. I wish to call your attention to an article on page 554 concerning T/4 Duane M. Kinman. For the records, it should be noted that T/4 Kinman was not a member of the 10th Infantry, but of the 2nd Infantry in the 5th Infantry Division, and the Regimental Surgeon was Major Alois Smitzel of Illinois. At the time I was Assistant Regimental Surgeon.

Respectfully,
M. T. GREENBURG, M.D.

9105 Van Dyke,
Detroit 13, Mich.

EDITOR'S NOTE—The information used when the article was prepared for THE JOURNAL was copied from the press—a news item, which could have been wrong. We are glad to make this correction.

Your 3 choices when treating diabetics...



WHEN A PHYSICIAN decides that a patient needs more than diet to control diabetes, he can now choose from three types of insulin. One is quick-acting and short-lived. Another is slow-acting and prolonged. Intermediate between these, is the third—the new 'Wellcome' Globin Insulin with Zinc. Its action begins with moderate promptness yet is sustained for sixteen or more hours—adequate to cover the period of maximum carbohydrate ingestion. By night, activity is sufficiently diminished to decrease the likelihood of nocturnal reactions. Physicians who consider the many advantages of this new third type of insulin now have another effective method of treating diabetes.

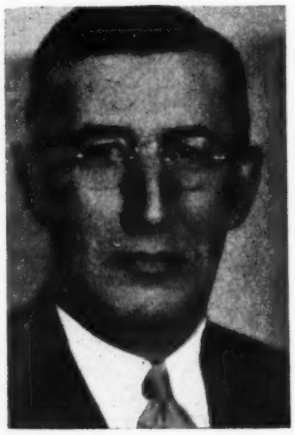
'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its relative freedom from allergenic properties. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in the Wellcome Research Laboratories, Tuckahoe, New York. U. S. Patent No. 2,161,198. Available in vials of 10 cc., 80 units in 1 cc., and vials of 10 cc., 40 units in 1 cc. Literature on request. 'Wellcome' trademark registered.

'WELLCOME'
Globin Insulin
WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

In Memoriam

Frederick C. Warnshuis, M.D.



In his sixty-sixth year, Frederick C. Warnshuis died January 6, 1946.

In the history of the Michigan State Medical Society it should be recorded that to Fred Warnshuis must go, in a large degree, the credit for the spade work which today makes possible this fine organization. That he receives from the profession too little credit for his accomplishments is due to certain unfortunate antagonisms which, in one way or another, he permitted to develop, generally quite unnecessarily.

As chairman of The Council, I worked with him intimately over many years, and came more and more to appreciate his exceptional natural ability. More than most men he had a vision of what the future of medicine would hold for the public and the physician. His reports as secretary of the State Medical Society give abundant evidence of this.

In his secretary's report to The Council in 1924 he proposed that "The Council be charged with the duty of providing and conducting, each year, in each councilor district, postgraduate courses, and medical educational clinics directed to the laity." This is but one of the many forward looking programs which he initiated and which came to fruition in the years after he had left the secretaryship of the Society.

For twenty years he was secretary of this Society, and handled its affairs with rare executive ability. During much of this period he was speaker of the House of Delegates of the American Medical Association where he presided with unusual efficiency. In 1934 he left us to become secretary of the California Medical Association. For the past few years he had been attached to the United States Consular Service, more recently assigned to Windsor, Ontario, where he died.

Doctor Warnshuis was an able surgeon. Butterworth Hospital, on whose staff he was, profited well by the example he set of beautiful technique and effective operating room procedure. His book on operating room technique for nurses at one time was used in many, if not most, of the larger nursing schools, both in this country and in Canada. He was active in many Grand Rapids civic affairs. He was one of the organizers of the Rotary Club of Grand Rapids. For many years he was on the State Board of Registration in Medicine. During World War I he was Lt. Colonel in charge of a

(Continued on Page 236)

SODASCORBATE

The new, *improved* Vitamin C Therapy

Mark well the word—"SODASCORBATE." Underscore it in your mental notebook. Photograph it in your mind. For SODASCORBATE offers distinct advantages to your patients who require vitamin C therapy, but who are unable to tolerate ordinary ascorbic acid.

The administration of this improved vitamin C is simplicity itself. The ***first*** and ***only*** sodium ascorbate in ***dry,*** neutral form, SODASCORBATE Tablets permit ***full*** and ***frequent*** doses of vitamin C without the gastric irritation, acid-shift or other undesired after-effects that so often result from large doses of straight ascorbic acid.

SODASCORBATE Tablets are indicated in clinical and sub-clinical scurvy, and in all conditions where vitamin C has been found of value. Recent studies suggest its use in infectious diseases and toxic conditions; in pregnancy and lactation; in allergies, especially hay fever; in some cases of gingivitis and pyorrhea; for lack of energy and endurance associated with vitamin C deficiency; and as a chlorine-free substitute for salt in heat exhaustion.

The average dose for adults and children over 12 years is one tablet three times daily, or as indicated by the condition. For children under 12, one-half tablet three times daily. May be dissolved in milk for babies and young children.

Supplied in bottles of 40 and 100 tablets, as well as in "hospital-size" bottle containing 500 tablets. For professional samples and covering literature, sign and mail the coupon.

NEWLY PUBLISHED

This 32-page monograph, "New Horizons in Vitamin C Therapy," tells about the therapeutic value of SODASCORBATE concisely, comprehensively, authoritatively. An exhaustive bibliography gives the busy physician a hasty "refresher course" in many new phases in vitamin C therapy. Mail the coupon for your copy.

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Please send professional samples of SODASCORBATE and 32-page monograph, "New Horizons in Vitamin C Therapy."

Dr._____

Address_____

Town_____State_____

(Continued from Page 232)

base hospital in France. He was a charter member of the American College of Surgeons, a member of the Society of Industrial Surgeons, and of many other medical organizations.

There must always be credits and debits as one sums up the successes and failures in any man's life. Fred Warnshuis had little formal educational background. He literally fought his way up into a position of prominence in the professional field by sheer hard work, hard study and aggressiveness. He resisted the many knocks that came his way. His credits stand high. Long after Fred Warnshuis is forgotten, his contributions to organized medicine and to the profession will live.

B.R.C.

* * *

Jay MacDonald Burgess of Detroit was born in 1873 in Drumbo, Ontario, and was graduated from the Michigan College of Medicine and Surgery in 1900. He began practice in Detroit, following graduation, and was on the staff of Providence Hospital for many years. Doctor Burgess was past president of the Vortex Club and a member of the Knights of the Round Table. He was interested in young people's activities and served for more than twenty years on the advisory council of the Detroit Area Boy Scouts of America and was one of the few persons in Detroit to receive the Silver Beaver. Doctor Burgess died December 8, 1945.

* * *

Roy W. Chivers of Jackson was born July 18, 1878 in Prattville, Michigan. He was graduated from the University of Michigan Medical School in 1900, and after graduation located in Jackson where he remained until the time of his death. He was the son of the late William Chivers, M.D., who also practiced medicine in Jackson for many years after coming to Jackson from Colon. Doctor Roy Chivers died October 25, 1945.

* * *

Neil A. Gates of Ann Arbor was born in Ann Arbor on March 16, 1873 and was graduated from the University of Michigan Medical School in 1897. He returned at various times for summer courses in Surgery. Doctor Gates practiced in Dexter, and operated a private hospital there for ten years. In 1907 he returned to Ann Arbor, and in 1924 he established the Gates Hospital which he operated until the time of his death, which occurred July 16, 1945.

* * *

Adolph A. Gronow of Detroit was born in 1870 and was graduated from the Detroit Homeopathic College in 1911. He practiced in Detroit for 34 years. Doctor Gronow died November 18, 1945.

* * *

Stewart Hamilton of Detroit was born in Detroit in 1880 and was graduated from the School of Pharmacy and the Medical School of Northwestern University in

(Continued on Page 240)

(Continued from Page 236)

1905. He served his internship at Harper Hospital. After his internship, he became industrial physician for the Copper Range Mine in Painesdale, Michigan. In 1909 he returned to Detroit to take up general practice. He was appointed assistant director of Harper Hospital in 1910 and in 1913 was made director. During World War I he was a captain in the medical corps of the Fourteenth Division and assigned to the Base Hospital at Camp Custer. Doctor Hamilton was one of the most eminent Americans in the field of hospital administration. He died December 18, 1945.

* * *

Harry A. Haze of Lansing was born in Lansing in 1868 and was graduated from the University of Michigan Medical School in 1895. He served one year on Doctor deNan Creed's surgical staff at the University, and then went abroad for postgraduate work in Berlin and Vienna. Returning to Michigan, he enlisted in the Army for the Spanish-American War. At its end Doctor Haze started practice in Lansing and served in many capacities. He was a member of Michigan's first medical registration board. He was a past president of Ingham County Medical Society; for six years he served as a member of the state school at Coldwater. He also served on the Lansing Board of Education, being twice named as its president. Doctor Haze died December 24, 1945.

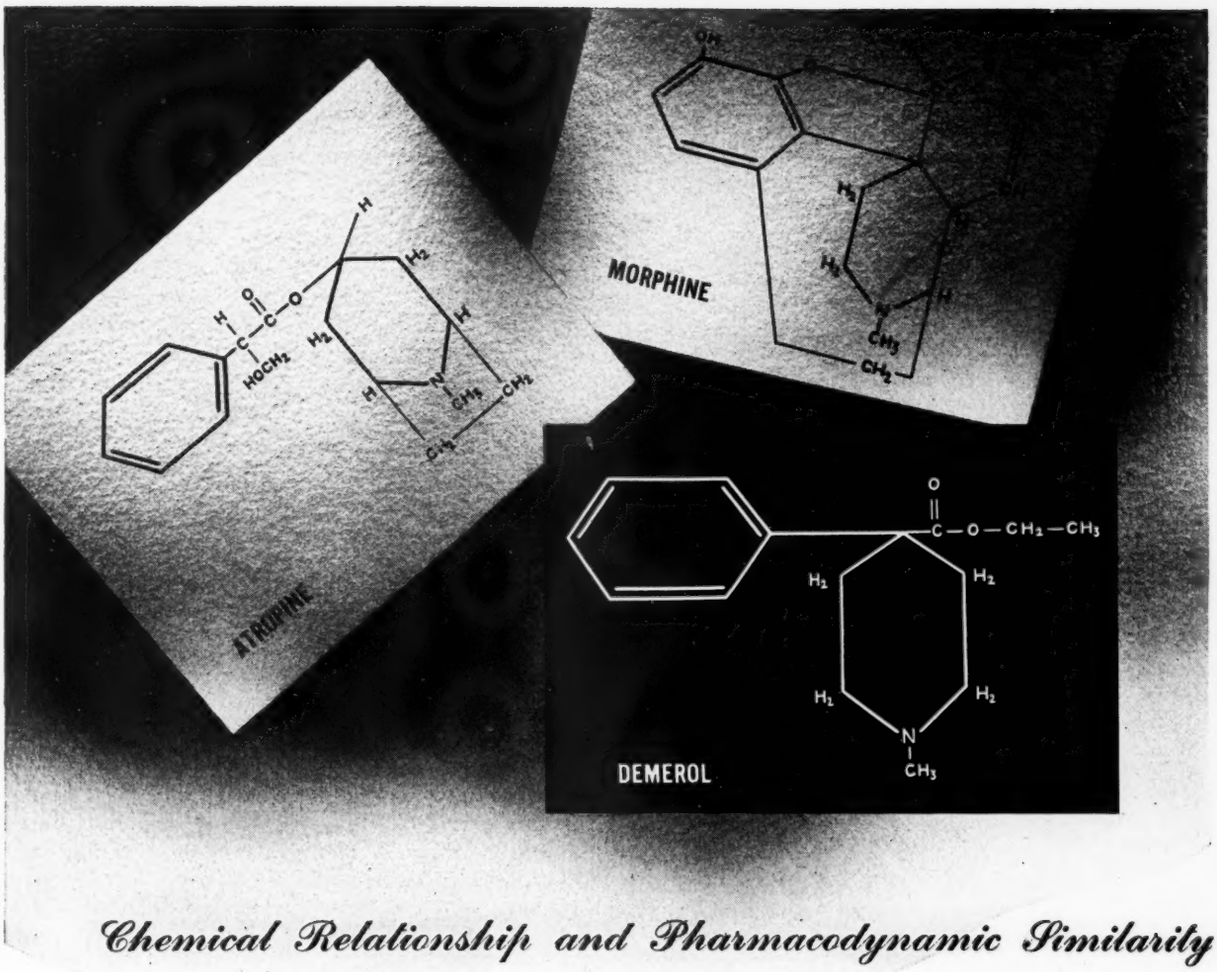
* * *

Alpheus Felch Jennings was born in Detroit in 1884 and was graduated from Harvard Medical School in 1910. He practiced in Detroit continuously since 1912, except during World War I. In 1917 he became medical officer at Selfridge Field; then assistant chief of medical service at the Custer Base Hospital. In 1918 he went overseas, and was successively attached to Evacuation Hospital 21, the Base Hospital at Camp Valdehon and the 82nd Division. He was discharged with the rank of Major. The son of Charles Godwin Jennings, for whom a memorial hospital was built by friends and admirers, Doctor Jennings followed in his father's footsteps beginning the practice of medicine in Detroit as his father's associate. He became head of Charles Godwin Jennings hospital. Following the death of his father in 1936, Doctor Jennings was a consultant on the staffs of the Detroit Tuberculosis Sanitarium, U. S. Marine Hospital and Receiving Hospital. He died November 16, 1945.

* * *

Stephen C. Mason of Menominee was born in Moberle, Mo., February 5, 1880 and was graduated from Rush Medical College in 1905. He served his internship at Gouveneur hospital in New York City. Doctor Mason located in Cherry, Ill., and in 1916 went to Menominee where he remained until the time of his death. He was a member of the Board of Education and many other civic organizations. He was a Past-President of the Upper Peninsula Medical Society and of the Menominee

(Continued on Page 242)



Chemical Relationship and Pharmacodynamic Similarity

A NEW SYNTHETIC

ANALGESIC — Demerol's analgesic power ranks between morphine and codeine.

SPASMOLYTIC — Demerol's spasmolytic action is similar to that of atropine.

SEDATIVE — Demerol's sedative effect is mild, but usually sufficient to allay restlessness and induce sleep.

PRACTICALLY NO RISK OF RESPIRATORY DEPRESSION

WRITE FOR DETAILED LITERATURE

DEMEROL
Trademark Reg. U. S. Pat. Off. & Canada
HYDROCHLORIDE
Brand of MEPERIDINE HYDROCHLORIDE
(Isonipecaine)

Average adult dose: 100 mg. orally or intramuscularly.

HOW SUPPLIED — **For oral use: Tablets of 50 mg., bottles of 25 and 100. For intramuscular injection: Ampuls of 2 cc. (100 mg.), boxes of 6 and 25, and vials of 30 cc. (50 mg. per 1 cc.).**

Subject to regulations of the Federal Bureau of Narcotics

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Pharmaceuticals of merit for the physician • New York 13 N. Y. • Windsor, Ont.

(Continued from Page 240)

County Medical Society. Doctor Mason died January 10, 1946.

* * *

Mansfield L. Spears, of Pontiac was born in Marianna, Florida, October 14, 1889 and was graduated from Meharry Medical College in 1917. He took postgraduate work in Columbia University and the University of Michigan. Doctor Spears had practiced in Pontiac for 24 years and was a member of the examining board of the A.M.E. Conference and Oakland County branch of the National Association for the advancement of Colored People. He died September 1945.

* * *

Harry F. Stamos of Detroit was born in Philiatra, Greece in 1903 and was graduated from the University of Michigan Medical School in 1929. He was former senior medical officer at the Detroit Naval Recruiting Station. Released from Service in 1944, Doctor Stamos reopened his practice of cardiology and internal medicine. He was consultant on the staff of St. Joseph Mercy Hospital. Doctor Stamos died December 12, 1945.

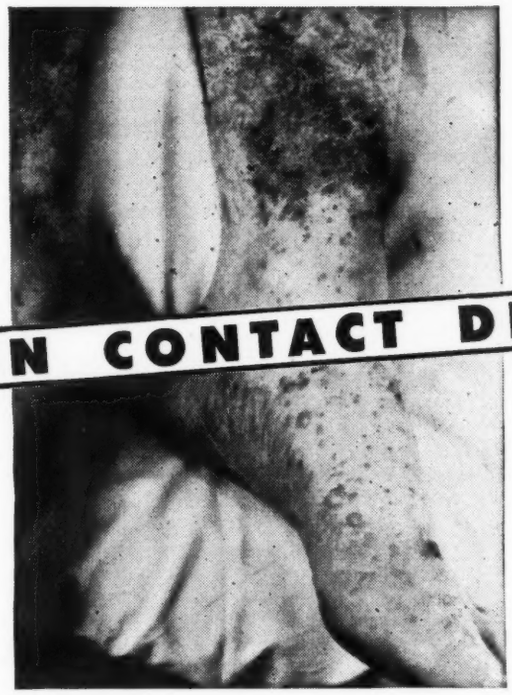
* * *

Henry Norton Torrey of Detroit was born in Creston, Iowa, October 7, 1880 and was graduated from Wayne University College of Medicine in 1906. During World War I, he served overseas as a major in the Army Medical Corps with the Harper Hospital Unit of Base Hospital 17. For a number of years he was active as a physician in the Detroit area. He was associated with a number of medical organizations and hospitals, including Michigan Mutual, Charles Godwin Jennings and Harper. Doctor Torrey died December 29, 1945.

DOCTORS NEEDED

(Continued from Page 212)

City	Pop.	County
Custer	237	Mason
Barryton	342	Mecosta
Sanford	250	Midland
McBain	489	Missaukee
Crystal	400	Montcalm
Lewiston	150	Montmorency
Hillman	363	Montmorency
North Muskegon	1694	Muskegon
Casnovia	289	Muskegon
Rose City	353	Ogemaw
Trout Creek	600	Ontonagon
Allendale	200	Ottawa
Fairview	150	Oscoda
The Heights	100	Roscommon
St. Charles	1300	Saginaw
Gardendale	100	St. Clair
Mendon	667	St. Joseph
Peck	381	Sanilac
Carsonville	433	Sanilac
Germfask	250	Schoolcraft
Perry	879	Shiawassee
Henderson	250	Shiawassee
Bancroft	581	Shiawassee
Gagetown	354	Tuscola
Fairgrove	481	Tuscola
Breedsville	184	Van Buren
Covert	600	Van Buren
Mattawan	312	Van Buren



IN CONTACT DERMATITIS

Subjective Relief as well as Rapid Resolution

THE basic pathogenicity of contact dermatitis consists of primary skin irritation, never a preexisting allergy. In consequence, any known irritant may affect anyone, depending upon individual susceptibility and duration of contact. In acute dermatitis vesiculation is seen, but in the more common subacute and chronic varieties, lichenification, fissuring, and scaling are the rule. Pruritus is usually severe, and is a prominent symptom. Tarbonis, providing the decongestant and stimulant properties of tar, quickly controls the annoying itching and encourages rapid resolution of the dermatitis itself. Avoidance of soap and water and cleansing with oil are beneficial auxiliary measures. Tarbonis will be found of outstanding efficacy in all types of contact dermatitis and industrial dermatoses.

Tarbonis is colorless, odorless, greaseless, does not stain linen or skin. It contains 5% Liquor Carbonis Detergens extracted from selected tar by a unique process, retaining all beneficial factors of tar and eliminating the irritants. Menthol and lanolin are also incorporated in the vanishing cream base, making for a preparation of unusual pharmaceutical elegance. Specifically indicated whenever the action of tar is required.

TARBONIS

REG. U. S. PAT. OFF.

THE TARBONIS COMPANY

4300 Euclid Avenue, Cleveland 3, Ohio

What's What

George C. Leckie, M.D., and Frank R. Bicknell, M.D., announce their association in the Practice of Urology, David Whitney Building, Detroit.

* * *

"Sex Endocrinology—For the Medical and Allied Professions," a new compendium, is available by writing Schering Corporation, Bloomfield, N. J.

* * *

Elmer H. Bobst, former president of Hoffman-LaRoche, Inc., has assumed the presidency and general direction of William R. Warner & Company, Inc., pharmaceutical manufacturers.

* * *

Labor is exerting great effort along the path of political power. The time is foreseen when labor may control the political agencies which in turn control the economic forces of the country.

* * *

The Gogebic County Medical Society publishes, periodically, a record of its members' attendance at County Society meetings. During the past year, out of twenty members, four have a 100 per cent score.

* * *

The Detroit Medical News (Bulletin of the Wayne County Medical Society) has instituted a "Veterans Page" containing suggestions and general information of value to veterans. Congratulations, DMN, on this valuable addition and innovation.

* * *

One hundred sixteen physicians died in action during 1945, according to JAMA. It is significant to note that 4,015 physicians died during 1945 as compared to 3,415 the previous year.

* * *

A new antibiotic plant for Michigan was announced by the Upjohn Company of Kalamazoo with the purchase of 500 acres near that city. Research work and large scale production of antibiotics will result from this expansion of facilities.

* * *

A. S. Brunk, M.D., Detroit, president of the Conference of Presidents and Other Officers of State Medical Associations, spoke on the "Aims and Purposes of the Conference of Presidents" at the National Conference on Medical Service, Palmer House, Chicago, February 10.

* * *

Mr. Wm. R. Niedelson, Detroit, has been appointed Michigan representative of the Electro-Physical Laboratories, Inc., New York (a division of Electronic Corpor-

(Continued on Page 246)

WHO—
Chicago Medical Society

WHAT—
Annual Clinical Conference

WHEN—
March 5, 6, 7, 8, 1946

WHERE—
Palmer House, Chicago, Illinois

WHY—

- **For Daily scientific programs consisting of half-hour lectures and clinics, beginning at 8:30 A. M. and continuing until 5:00 P. M.**
- **To inspect scientific and technical exhibits**
- **To hear new ideas presented by outstanding clinicians from all sections of the United States**
- **To renew acquaintances**
- **To relax away from your own office**
- **To attend a banquet on Thursday night**

HOW—

By making YOUR reservation through The Chicago Convention Bureau, 33 North LaSalle Street, Chicago 2, Illinois.

Registration Fee $5.00

(Continued from Page 244)

ation of America). He will continue the sales and service of the Jones Metabolism machines in addition to the EPL.

* * *

Lt. Col. A. R. Woodburne, M. C. (formerly of Grand Rapids) has accepted a teaching position with the University of Colorado Medical School in the Department of Dermatology, and will open a professional office in Denver, in association with Professor O. S. Philpott, M.D., and A. J. Markley, M.D.

* * *

Louis J. Gariepy, M.D., and Paul G. Henley, M.D., Detroit, are authors of an original article "Acute Suppurative Appendicitis with Abscess Formation and Subsequent Perforation of the Anterior Abdominal Wall" which appeared in the *American Journal of Surgery,* December, 1945.

* * *

The American College of Surgeons announces it will hold ten sectional meetings, one to be held in Detroit, at the Statler Hotel, March 26-27.

The medical profession at large is invited to join with the Fellows of the ACS in this meeting.

For the program write ACS, 40 E. Erie Street, Chicago.

* * *

JMSMS of December 1945 was the largest Number in the recent history of the Michigan State Medical Society —160 pages. In addition to the scientific articles, it contained the Proceedings of the 1945 MSMS House of Delegates, the Annual Index, and a 20-page insert of the Proceedings of the Conference of Presidents and Other Officers of State Medical Associations.

* * *

The National Gastroenterological Association announces the establishment of an Annual Cash Prize Award of $100 for the best unpublished contribution on gastroenterology or allied subjects. Entries are limited to 5,000 words, to be received not later than May 1, 1946. Entries should be addressed to the Association at 1819 Broadway, N. Y. 23.

* * *

The Detroit Times is to be commended for a fine civic gesture in assisting the returning doctor of medicine by publishing a feature list of the returned veterans of Wayne, Macomb and Oakland counties.

Such a friendly gesture is of value to the individual medical veteran, as it aids him in his problems of relocation. It also furthers the work of the MSMS Medical Veterans Readjustment Program.

* * *

The Fourteenth Councilor District meeting was called in the Michigan League Building, Ann Arbor, by Councilor D. W. Myers, M.D. on January 10. Talks were presented by President R. S. Morrish, M.D., Flint, on "Medical Education"; Secretary L. Fernald Foster, M.D., Bay City, "Report on House of Delegates Actions;" John W. Castellucci, Detroit, of Michigan Medical Serv-

(Continued on Page 248)

(Continued from Page 246)

ice, on "The V. A. Program of Michigan"; and Executive Secretary Wm. J. Burns, Lansing, who spoke on "New Activities of the State Society."

* * *

The MSMS Public Relations Committee recommends to county and district medical societies that they create inter-professional councils, and also that they hold annually a meeting at which representatives of other professional groups and civic leaders are guests of the medical society.

Such meetings have achieved desirable and outstanding results in St. Clair and Wayne Counties.

* * *

Beautiful four-color inserts have been a regular feature of JMSMS for some years. The number of advertisers using color, including four-color inserts, is increasing.

Incidentally, the number of advertisers who appreciate the readability of JMSMS is also gaining. The Editor voices his appreciation to the membership for its continued interest and growing participation in the Michigan State Medical Journal.

* * *

"Only Mr. Truman himself can say whether his national health program was intended to bamboozle the unwary or whether he really believes that private medicine can continue to grow in quality and availability under the system he proposed. Some of us may suspect the worst, but (Lord help us!) we can't be sure. What we do know is that the President has asked us to accept a scheme which is bound to result in a steady deterioration of medical standards."—WILBER J. BRONS in *Chicago Journal of Commerce*, November 30, 1945

* * *

The Third Councilor District Meeting was held, under the leadership of Councilor Wilfrid Haughey, M.D., at the Hart Hotel, Battle Creek, on February 5. Eighty-three were present.

President R. S. Morrish, M.D., Flint spoke on "Health Education Needs of Michigan"; L. Fernald Foster, M.D., Bay City, spoke on "Uniform Fee Schedule for Governmental Agencies"; J. C. Ketchum, Detroit, Executive Vice President of Michigan Medical Service, spoke on "The Michigan Plan for Medical Care of Veterans"; and Wm. J. Burns, Lansing, Executive Secretary of MSMS, spoke on "Progressive Michigan Medicine."

* * *

The Sixth Councilor District meeting was held at the City Club of Owosso on Friday, January 25. Councilor R. C. Pochert, M.D., was toastmaster and introduced the speakers.

President R. S. Morrish, M.D., Flint, spoke on "Medical Education"; Secretary L. Fernald Foster, M.D., Bay City, presented "The Uniform Fee Schedule for Governmental Agencies"; and J. C. Ketchum, Detroit, Executive Vice President, Michigan Medical Service, outlined the "Veterans Administration Home and Office Medical Care Program for Michigan."

(Continued on Page 250)

(Continued from Page 248)

The Wayne County Medical Society recently polled its membership with a questionnaire seeking the following information:

Are you in favor of the Wagner-Murray-Dingell Bill? Yes ☐ No ☐

Are you a general practitioner? Yes ☐ No ☐

Have you at any time served in the medical corps of the United States armed forces? Yes ☐ No ☐

In what congressional district do you vote? ————.

The signing of the post card was optional.

The covering letter stated "In order that the public, who are your patients, and the Congressmen, who are your representatives, may know how *you* stand, *you* must answer the enclosed questionnaire. The proponents of this legislation have publicly stated that only a reactionary minority of the medical profession oppose it."

* * *

A Half Ton of Tonsils

During the three-year period from April 1, 1942, to March 31, 1945, Michigan Medical Service paid for the removal of 43,492 pairs of tonsils. Estimate the weight yourself. During the same period there were 27,372 deliveries, and 17,170 appendectomies.

* * *

Some Figures

Up to December 31, 1945, Michigan Medical Service had paid to doctors $13,628,000.00. During the year 1945 the doctors received $4,143,000.00 for their services. This sounds like real service.

Research Grant

The Board of Education has accepted for Wayne University Medical School $500 to be used for research on multiple sclerosis at the College of Medicine. This project is under the direction of Dr. Gabriel Steiner, associate professor of neuropathology; also a grant of $1,200 from the American Medical Association for the continuation of research on urogastrone.

* * *

Cancer Symposium

A scientific program devoted entirely to the subject of Cancer, will be held in Merliss Brown Auditorium, Hurley Hospital, Flint, Michigan, on March 20, 1946.

The tentative program is as follows:

"Cancer of the Uterus"—Louis E. Phaneuf, M.D., Professor of Gynecology, Tufts College Medical School, Boston, Massachusetts.

"Cutaneous Malignancy"—Paul A. O'Leary, M.D., Chief of the Department of Dermatology, Mayo Clinic, Rochester, Minnesota.

"Cancer of the Genito-Urinary System"—Charles B. Huggins, M.D., Professor, Urology, University of Chicago Medical School.

"Cancer of the Stomach"—Frederick A. Coller, M.D., Professor of Surgery, University of Michigan Medical School.

"Cancer of the Breast"—Frank E. Adair, M.D., Clinical Director, Department of Surgery, Memorial Hospital, New York City, N. Y.

MSMS members are cordially invited to attend this

(Continued on Page 252)

(Continued from Page 250)

meeting. For final program, write George J. Curry, M.D., Chairman, Genesee County Medical Society Program Committee, Begole St., Flint, Michigan.

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General Lull Leaves SGO FOR AMA

Major General George F. Lull, Deputy Surgeon General of the Army, whose notable record in that capacity won him the Distinguished Service Medal, the highest noncombatant award, has retired from the Army after 33 years of service with the Medical Corps.

General Lull will become Secretary and General Manager of the American Medical Association. He will take up his new duties officially in July, when the retirement of Dr. Olin West, the present Secretary and General Manager, becomes effective, but he will immediately join the staff of the American Medical Association to familiarize himself with the work of the organization.

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AMA Voluntary Sick Insurance Plan

On February 15, 1946 the Board of Trustees and the Council on Medical Service and Public Relations announced preliminary plans for a nationwide system of voluntary non-profit sickness insurance to be administered by a newly formed subsidiary Associated Medical Care Plans, Inc. While premiums will vary in different parts of the country they will be much less than the projected Truman's compulsory health insurance program.

To display the Association's seal of approval they must have the approval of the state or county medical society; the medical profession in the area must assume responsibility for the medical services included in the benefits; they must provide for the free choice of doctor of medicine, and maintain the personal, confidential patient-physician relationship; they must be organized and operated to provide the greatest possible benefits to the subscribers. Benefits may be cash indemnity or units of medical service, including home, office and hospital calls.

Existing plans will be coordinated and reciprocity established. A central clearing house will be established at the AMA headquarters in Chicago.

This action following the directive of the House of Delegates now makes it possible to offer the nation a comprehensive voluntary non-profit substitute for the unAmerican, socialistic, compulsory and enormously expensive plan of the international labor group which the President and his friends Wagner, Murray and Dingell have adopted as their own. The program is already proposed by the Conference of Presidents and Other Officers, and is printed on page 48 of the January issue, JMSMS.

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Rheumatic Fever Control

The Michigan Rheumatic Fever Control program is another first for Michigan, and is stressed in this number of THE JOURNAL. The consultation and diagnostic center areas appear on page 160. Also three papers read at the Michigan Rheumatic Fever Control Conference in Detroit September 19-20, 1945 are published on pages 193, 197, and 202. Michigan State Medical Society interest in this subject is active and is producing results.

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

YOUR CARE DURING PREGNANCY. Medical instructions for the mother-to-be. Ann Arbor: The Cadeuceus Press, 1945. Price $0.25 (minimum orders 20).

The material contained in this booklet is identified with that in use by the Department of Obstetrics of the University of Michigan, and was prepared by the staff of the University. The instructions given are full, sound, and will save the busy obstetrician hours of his valuable time in giving his patients advice as to a trying time in their lives. It is planned to provide these 32-page booklets, attractive and paper bound so the doctor may dispense them as he would other instructions or medications. They may be had in lots of 100 or more for $0.20, and the doctor may have his name inprinted for $2.00.

CLASSIC DESCRIPTIONS OF DISEASE. With Biographical Sketches of the Authors. By Ralph H. Major, M.D., Professor of Medicine, University of Kansas School of Medicine, Springfield, Illinois: Charles C. Thomas, 1945. Price $6.50.

In this volume of 641 pages the author has collected the original, or a translation into English of the original description of two hundred and eighty-seven clinical entities. There are George Dock's description of the first American diagnosis during life and postmortem proof of Coronary occlusion. Banting's first report of Insulin, Hieronymus Fracastorius' "De morbis contagiosis," Walter Reed's "The Etiology of Yellow Fever," William Eithering's account of The Introduction of Foxglove into Modern Medicine; John C. Otto's "Hemophilia. There are also brief accounts of the life of the authors. This is a third edition, and is of most unusual interest. One can brouse away in the past and learn many things he least expected about the growth of modern medicine, from the Papyrus Ebers and Hippocrates to our still living investigators.

TEXTBOOK OF PEDIATRICS (Mitchell-Nelson). Edited by Waldo E. Nelson, M.D., Professor of Pedatrics, Temple University School of Medicine, with the collaboration of 49 contributors; 1,350 pages, 519 illus. Fourth edition, revised. Philadelphia: W. B. Saunders Company, 1945. Price, $10.00.

This textbook, while the fourth edition, based on the previous work of Griffith and Mitchell, is in reality a new book. It has many features which make it one of the most usable and readable sources of information to be added to the publications on pediatrics in many years. Forty-nine contributors, all specialists in their respective branches, assist in making this an up-to-date and authoritative text. The type is large, yet the work is condensed into one volume. Very little space is allotted to history and only those references retained which apply to the understanding of present problems. The charts, photographs, and x-ray plates are particularly good. Compre-

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hensive cross-references make the work especially valuable in obtaining details of a subject quickly. The first 210 pages deal with child development, nutritional requirements, and drug therapy. The discussion is as usable by the general practitioner and specialist as by the inexperienced student. The accepted indications, contraindications, and methods of use of the sulfonamides and penicillin are well presented. S.T.L.

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MODERN UROLOGY FOR NURSES. By Sheila Maureen Dwyer, R.N., B.S., Director School of Nursing and Nursing Service Southampton Hospital, Southampton, N. Y., et cetera, and George W. Fish, M.D., Associate Professor of Urology, College of Physicians and Surgeons, Columbia University, New York City; With a Foreword by Helen Young, R.N., Director Emeritus, School of Nursing and Nursng Service, Columbia-Presbyterian Medical Center in the City of New York. Philadelphia: Lea & Febiger, 1945. Price $3.25.

The floor plan, personnel and equipment for a urological service are described in this little book. Lists of the various instruments and supplies needed for the examinations and treatments are given. The diseases and objectives in diagnosis are carefully and briefly outlined. The text is sufficiently full of detail, well oriented and will make an excellent guide for the nurse.

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TAKE IT EASY. The Art of Conquering Your Nerves. By Arthur Gay Mathews. Twenty-six symbolical illustrations by the author. New York: Sheridan House, 1945. Price $2.98.

Many of the ills to which the profession must give its best attention are ills of the mind, stimulated or guided, or controlled by the mental efforts of the patient. So many apparently grave disorders will respond to well-directed suggestion in the form of sugar pills. The necessary disederatum is to teach the patient nerve control. Take it Easy is easy to say, but methods are given in this entertaining little book. To the psychiatrist it should be a wholesome diversion. To the general practitioner it will stimulate so many thoughts that will help that he should read it.

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CANCER OF THE COLON AND RECTUM: Its Diagnosis and Treatment. By Fred W. Rankin, B.A., M.A., M.D., Sc.D., F.A.C.S., Surgeon, St. Joseph's and Good Samaritan Hospitals, Lexington, Kentucky, and A Stephens Graham, M.D., M.S. (in surgery), F.A.C.S., Surgeon, Stuart Circle Hospital, Richmond, Virginia, Assistant Professor of Surgery, Medical College of Virginia. Springfield, Illinois: Charles C. Thomas, 1945. Price: $5.50.

The authors of this concise work are to be congratulated. All of the essentials of diagnosis and treatment, including choice of operation, are covered thoroughly. A good book for the general practitioner or the specialist.

A.M.G.

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DISEASES OF THE NOSE, THROAT AND EAR: Edited by Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Broncho-Esophagology, Temple University, Philadelphia; and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Broncho-Esophagology, Temple University, Philadelphia. With the Collaboration of 64 Outstanding Authorities. 844 pages with 934 illustrations on 581 figures including 18 plates in color. Philadelphia and London: W. B. Saunders Company, 1945. Price $10.00.

As in all their other works the Jacksons have produced a masterpiece in this text. It is complete with every conceivable subject well covered. As would be expected half

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of the volume is devoted to the larynx and hypopharynx, the trachea and bronchi. Methods of diagnosis and treatment with the use of the direct laryngoscope and bronchoscope are profusely detailed. Illustrations are the last word. This book is a complete text and guide to exact and painstaking work in a field developed by the authors.

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PEDIATRIC X-RAY DIAGNOSIS. A Textbook for Students and Practitioners of Pediatrics, Surgery and Radiology. By John Caffey, A.B., M.D., Associate Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, Associate Pediatrician and Roentgenologist, Babies Hospital and Vanderbilt Clinic, New York City. Consulting Pediatrician, Grasslands Hospital, Westchester County, N. Y., and St. John's Hospital, Yonkers, N. Y. Chicago: The Year Book Publishers, 1945. Price, $12.50.

This is the first textbook on the radiological aspect of pediatrics to come out in several years. It answers a long-felt need. The author has compiled a wide variety of information into a book of convenient size. The print is extremely easy on the eye. Pertinent information is condensed into clear, concise paragraphs. Illustrations are excellently reproduced and the large number of plates adds much to the book's worth. An adequate bibliography folows each section.

The section on the thorax is very inclusive and shows the author's main interest. A wide variety of congenital variations which have been included makes this book a good reference.

Pediatricians, radiologists and anyone interested in pediatrics will find this a welcome addition to his library.

G.T.P.